Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions for Dental Services Provider Type – 60, 61

Version 5.1

May 17, 2019

Document Change Log

Document Version	Date	Name	Comments
1.0	10/14/2005	EDS	Initial creation of DRAFT Home Health Services Provider Type – 60, 61
1.1	01/19/2006	EDS	Updated Provider Rep list
1.2	02/16/2006	Carolyn Stearman	Updated with revisions requested by Commonwealth.
1.3	03/28/2006	Lize Deane	Updated with revisions requested by Commonwealth. v1.2 – 1.3 are actually the same as revisions were made back-to-back and no publication would have been made
1.4	06/09/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.5	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.6	01/03/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
1.7	01/08/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
1.8	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
1.9	02/15/2007	Ann Murray	Updated Appendix B, KY Medicaid card and ICN.
2.0	02/21/2007	Ann Murray	Replaced Provider Rep table.
2.1	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v1.6 – 2.1 are actually the same as revisions were made back-to-back and no publication would have been made
2.2	05/03/2007	Ann Murray	Updated and added claim forms and descriptors.
2.3	06/20/07	John McCormick	Updated Rep list
2.4	03/17/2008	Ann Murray	Added ordering information to Section 6
2.5	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.

Document Version	Date	Name	Comments
2.6	06/11/2008	Ann Murray	Deleted without NPI and with NPI and Legacy claim forms and instructions.
2.7	03/10/2009	Cathy Hill	Replaced KYHealth Choices with KY Medicaid per Stayce Towles
2.8	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept for Medicaid Services per Stayce Towles
2.9	03/30/2009	Ann Murray	Made global changes per DMS request. v2.7 – 2.9 are actually the same as revisions were made back-to-back and no publication would have been made
3.0	09/08/2009	Ann Murray	Replaced Provider Rep list.
3.1	10/21/2009	Ron Chandler	Replace all instances of “EDS” with “HP Enterprise Services”.
3.2	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @hp.com. Removed the HIPAA section. v3.1 – 3.2 are actually the same as revisions were made back-to-back and no publication would have been made
3.3	3/9/2010	Ron Chandler	Insert new provider rep list.
3.4	7/9/2010	Ron Chandler	Revise Form locator 35 remarks per Patti George email.
3.5	11/15/2010	Patti George Ron Chandler	Revise Form locator 38 remarks per Patti George email and transmittal methods section 6.6.
3.6	01/18/2011	Ann Murray	Updated global sections.
3.7	05/04/2011	Patti George	Replace occurrences of SHPS with Carewise Health, Inc.
3.8	02/07/2012	Stayce Towles Ann Murray	Removed “Prior authorization request for Periodontal Scaling, Root Planning, and Panoramic x-rays shall be submitted to: HP Enterprise Services Attn: Dental Department P. O. Box 5350 Frankfort, KY 40601” from page 34. Approved by Charles Douglass, 02/13/2012
3.9	02/10/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
4.0	02/22/2012	Brenda	Global updates made to remove all references to

Document Version	Date	Name	Comments
		Orberson Ann Murray	KenPAC and Lockin. DMS Approved 03/09/2012, John Hoffman
4.1	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
4.2	08/31/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012
4.3	01/31/2013	Vicky Hicks Patti George	Update section 1.2.2.2 to reflect former Passport Members having a choice of MCOs as of 1/1/2013. DMS Approved 02/27/2013, John Hoffman
4.4	06/28/2013	Vicky Hicks Patti George	Updates to NET PAYMENT and NET EARNINGS descriptions in Section 9.10.1 DMS Approved 07/09/2013, John Hoffman
4.5	08/13/2013	Stayce Towles Patti George	Update to section 5.10- Provider Rep listing.
4.6	04/11/2014	Stayce Towles	Update to sections 1-5 per DMS. Also approved on 4/11/14, Lee Guice.
4.7	07/17/2015	Stayce Towles	Updated place of service codes per CO 24859
4.8	06/17/2016	Vicky Hicks	Added place of service code 19 per CO26401, updated rep list Approved by Charles Douglass, DMS 6/16/2016
4.9	02/01/2017	Vicky Hicks	Added “Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides.” Approved by Charles Douglass, DMS, 2/1/17 Added “Enter the Referring Provider NPI and taxonomy, if applicable. This information should be left justified in this field.“ to form locator 35 of the ADA Claim Form paper billing instructions. Approved by Charles Douglass, DMS, 2/8/2017
5.0	01/22/2018	Vicky Hicks	Replaced Subtotal and Total due entry instructions on the ADA claim form. Approved by Charles Douglass, DMS 1/22/2018
5.1	05/17/2019	Vicky Hicks	Updated: 1) HP/HPE to DXC, hpe.com to

Document Version	Date	Name	Comments
		Mary Larson	dxc.com, 2) Provider Rep Table, 3) all forms, 4) DMS URLs in Introduction, 5) Added Place of Service code 02 – Telehealth per CO29475

TABLE OF CONTENTS

1 General

1.1 Introduction

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

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

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

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

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

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

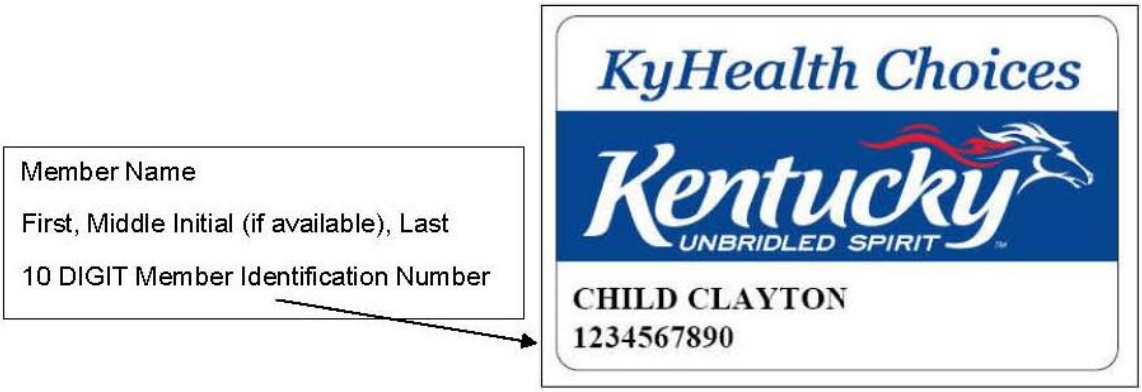
1.2 Member Eligibility

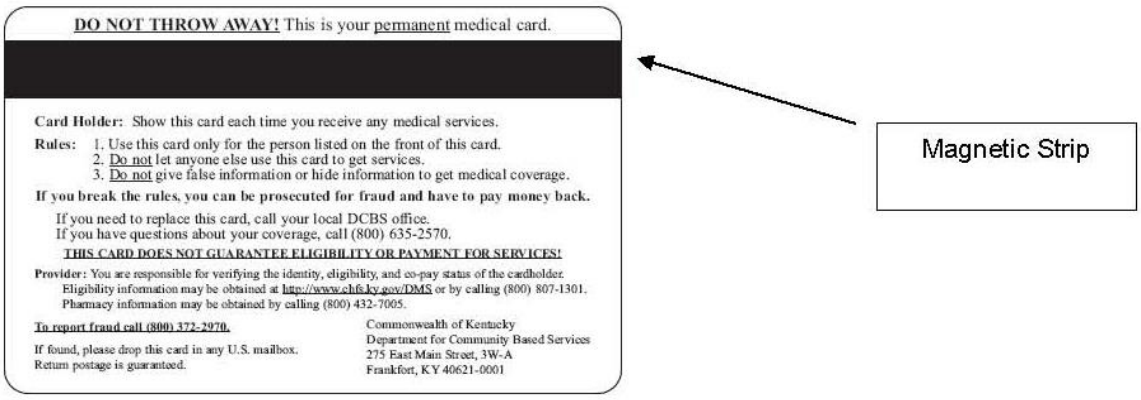
Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through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

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

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

1.2.1 Plastic Swipe KY Medicaid Card





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

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

1.2.2 Member Eligibility Categories

1.2.2.1 QMB and SLMB

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

1.2.2.2 Managed Care Partnership

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

1.2.2.3 KCHIP

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

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

1.2.2.4 Presumptive Eligibility

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

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

- PE for pregnant women
- PE for hospitals

1.2.2.4.1 PE for Pregnant Women

1.2.2.4.1.1 Eligibility

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

1. A family or general practitioner;
2. A pediatrician;
3. An internist;
4. An obstetrician or gynecologist;
5. A physician assistant;
6. A certified nurse midwife;
7. An advanced practice registered nurse;
8. A federally-qualified health care center;
9. A primary care center;
10. A rural health clinic
11. A local health department

Presumptive eligibility shall be granted to a woman if she:

1. Is pregnant;
2. Is a Kentucky resident;
3. Does not have income exceeding 195 percent of the federal poverty level established annually by the United States Department of Health and Human Services;
4. Does not currently have a pending Medicaid application on file with the DCBS;
5. Is not currently enrolled in Medicaid;
6. Has not been previously granted presumptive eligibility for the current pregnancy; and
7. Is not an inmate of a public institution

1.2.2.4.1.2 Covered Services

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

1. Services furnished by a primary care provider, including:
    a. A family or general practitioner;
    b. A pediatrician;
    c. An internist;
    d. An obstetrician or gynecologist;

e. A physician assistant;

f. A certified nurse midwife; or

g. An advanced practice registered nurse;

2. Laboratory services;
3. Radiological services;
4. Dental services;
5. Emergency room services;
6. Emergency and nonemergency transportation;
7. Pharmacy services;
8. Services delivered by rural health clinics;
9. Services delivered by primary care centers, federally-qualified health centers, and federally-qualified health center look-alikes; or
10. Primary care services delivered by local health departments.

1.2.2.4.2 PE for Hospitals

1.2.2.4.2.1 Eligibility

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

1. Does not have income exceeding:
    a. 138 percent of the federal poverty level established annually by the United States Department of Health and Human Services; or
    b. 200 percent of the federal poverty level for children under age one and 147 percent of the federal poverty level for children ages 1-5 as established annually by the United States Department of Health and Human Services, if the individual is a targeted low-income child;
2. Does not currently have a pending Medicaid application on file with the DCBS;
3. Is not currently enrolled in Medicaid; and
4. Is not an inmate of a public institution

1.2.2.4.2.2 Covered Services

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

1. Services furnished by a primary care provider, including:
    a. A family or general practitioner;

b. A pediatrician;

c. An internist;

d. An obstetrician or gynecologist;

e. A physician assistant;

f. A certified nurse midwife; or

g. An advanced practice registered nurse;

2. Laboratory services;
3. Radiological services;
4. Dental services;
5. Emergency room services;
6. Emergency and nonemergency transportation;
7. Pharmacy services;
8. Services delivered by rural health clinics;
9. Services delivered by primary care centers, federally-qualified health centers and federally-qualified health center look-alikes;
10. Primary care services delivered by local health departments; or
11. Inpatient or outpatient hospital services provided by a hospital.

1.2.2.5 Breast & Cervical Cancer Treatment Program

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

1.2.3 Verification of Member Eligibility

This section covers:

- Methods for verifying eligibility;
- How to verify eligibility through an automated 800 number function;
- How to use other proofs to determine eligibility; and
- What to do when a method of eligibility is not available.

1.2.3.1 Obtaining Eligibility and Benefit Information

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

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- KY HealthNet at https://home.kymmis.com;
- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except holidays.

1.2.3.1.1 Voice Response Eligibility Verification (VREV)

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

The VREV system generally processes calls in the following sequence:

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

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

1.2.3.1.2 KY HealthNet Online Member Verification

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

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

2 Electronic Data Interchange (EDI)

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

2.1 How to Get Started

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

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

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

2.2 Format and Testing

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

2.3 ECS Help

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

3 KY HealthNet

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

3.1 How to Get Started

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

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

3.2 KY HealthNet Companion Guides

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

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

4 General Billing Instructions for Paper Claim Forms

4.1 General Instructions

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

4.2 Imaging

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

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

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

4.3 Optical Character Recognition

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

5 Additional Information and Forms

5.1 Claims with Dates of Service More than One Year Old

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

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

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

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

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

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

5.2 Retroactive Eligibility (Back-Dated) Card

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

5.3 Unacceptable Documentation

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

5.4 Third Party Coverage Information

5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

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

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

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

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

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

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

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

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

5. Letter from an employer that includes:
   - Member name;
   - Date of insurance or employee termination or effective date (if applicable); and,
   - Employer letterhead or signature of company representative.

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

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

5.4.4 For Accident and Work Related Claims

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

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

5.4.4.1 TPL Lead Form

DXC Technology

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

Third Party Liability Lead Form

Provider Name: _____ Provider #: _____

Member Name: _____ Member #: _____

Address: _____ Date of Birth: _____

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

Date of Admission: _____ Date of Discharge: _____

Insurance Carrier Name: _____

Address: _____

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

Date Claim was Filed with Insurance Carrier: _____

Please check the one that applies:

_____ No Response in over 120 Days

_____ Policy Termination Date: _____

_____ Other: Please explain in the space provided below

_____
_____
_____
_____

Contact Name: _____ Contact Telephone #: _____

Signature: _____ Date: _____

DMS Approved: January 10, 2011

5.5 Provider Inquiry Form

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

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

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

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

Provider Inquiry Form

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

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

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

Providers Message

_____

Signature/Date

DXC TECHNOLOGY RESPONSE:

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

Other: _____

_____

_____

Signature/Date

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

5.6 Prior Authorization Information

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

Access the kymmis website to obtain blank Prior Authorization forms.

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

Access to Electronic Prior Authorization request (EPA).

https://home.kymmis.com

5.7 Adjustments and Claim Credit Requests

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

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

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

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form. For a Medicaid/Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) to the claim;
- Do not send refunds on claims for which an adjustment has been filed;
- Be specific. Explain exactly what is to be changed on the claim;
- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim requires an adjustment; and,
- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely.

DXC Technology

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

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

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

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

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

_____

_____

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

_____

_____

_____

13. Signature _____ 14. Date _____

DMS Approved: January 10, 2011

5.8 Cash Refund Documentation Form

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

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

Please keep the following points in mind when refunding:

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

DXC Technology

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

CASH REFUND DOCUMENTATION

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

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

Research for Refund: (Check appropriate blank)

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

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

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

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

_____

_____

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

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

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

_____

_____

_____

Contact Name _____ **Phone** _____

DMS Approved: January 10, 2011

5.9 Return to Provider Letter

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

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

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

Other reasons for return may include:

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

DXC

RETURN TO PROVIDER LETTER

Date: _____ - _____ - _____

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

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

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

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

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

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

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

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

08) Other Reason

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

Helpful Hints When Billing for Services Provided to a Medicaid Member

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

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

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

Initials of Clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Phone Numbers and Assigned Counties

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

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

6 Dental Claim Form Billing Instructions

6.1 General

Handwritten claims should be printed using black ink. All information entered on the claim form should be legible and easy to read. Typewritten claims are preferred. Electronic billing is recommended to optimize claim turnaround. Contact DXC Technology Electronic Claims Submission Unit at 1-800-205-4696 to obtain instructions on filing claims electronically.

6.2 Where to Order

www.ada.org or by calling 1-800-947-4746

6.3 Mailing Information

Send the completed original ADA claim form to DXC Technology for processing as soon as possible after the service is rendered. Retain a copy in the office file.

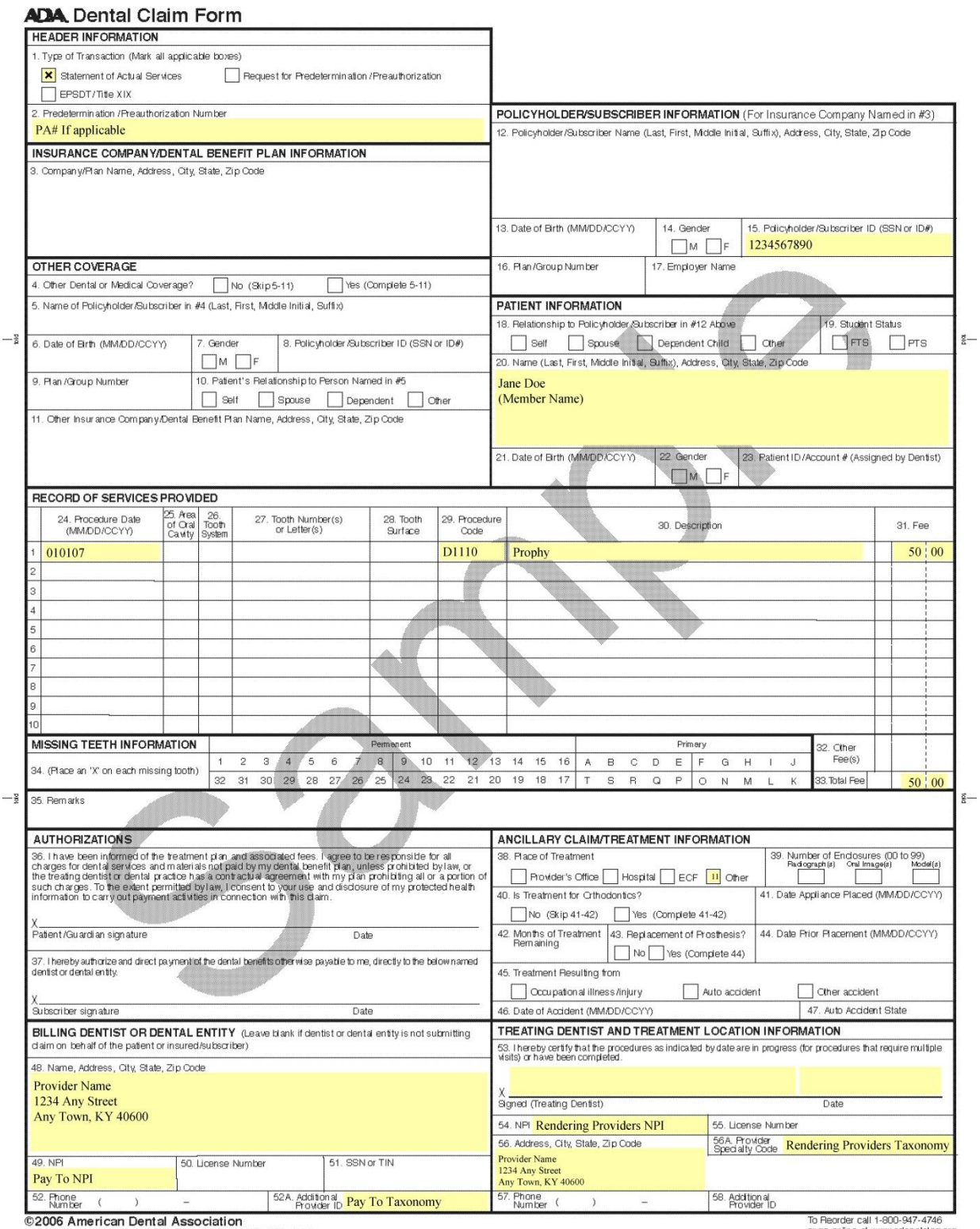
Mail completed claims to:

DXC Technology
PO Box 2101
Frankfort, KY 40602-2101

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

Completion of Dental Claim – ADA 2006 Version with NPI and Taxonomy

NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [X] Statement of Actual Services
   - [ ] Request for Predetermination /Preauthorization
   - [ ] EPSDT/Title XIX
2. Predetermination /Preauthorization Number: PA# If applicable

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? [ ] No (Skip 5-11) [ ] Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender [ ] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#): 1234567890
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Student Status [ ] FTS [ ] PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Jane Doe (Member Name)
21. Date of Birth (MM/DD/CCYY)
22. Gender [ ] M [ ] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	010107					D1110	Prophy	50 00
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee: 50 00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Patient/Guardian signature _____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Subscriber signature _____ Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code: Provider Name, 1234 Any Street, Any Town, KY 40600
49. NPI: Pay To NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) –
52A. Additional Provider ID: Pay To Taxonomy

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment [ ] Provider's Office [ ] Hospital [ ] ECF [11] Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____ Signed (Treating Dentist) _____ Date

54. NPI: Rendering Providers NPI
55. License Number
56. Address, City, State, Zip Code: Provider Name, 1234 Any Street, Any Town, KY 40600
56A. Provider Specialty Code: Rendering Providers Taxonomy
57. Phone Number ( ) –
58. Additional Provider ID

Completion of Dental Claim – ADA 2006 with NPI Version

NOTE: These instructions are related to the billing aspect of the dental program. For policy related issues (for example, age limitations) please refer to the Dental regulation. 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.

2006 VERSION FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	**Type of Transaction**
	Check the box Statement of Actual Services.
2	**Predetermination/ Preauthorization Number**
	If the procedure requires prior authorization; enter the 10-digit authorization number.
4	**Other Dental or Medical Coverage**
	Check "Yes" if payment has been made by any kind of health insurance other than Medicare. If marked yes, complete fields 5-11.
15	**Subscriber Identifier (SSN or ID #)**
	Enter the member's 10-digit identification number exactly as it appears on the current Member Identification card.
20	**Name, Address, City, State, Zip Code**
	Enter the first name, middle initial, and last name of the member exactly as it appears on the current Member Identification card.
23	**Patient ID/ Account # (Assigned by Dentist)**
	Enter the patients account number, up to 20 digits. This is the invoice number on your remittance advice (optional not required).
24	**Procedure Date**
	On each line, enter the date on which the service was provided in month, day, and year sequence and in numeric format.
27	**Tooth Number or Letter**
	Enter the tooth identification number or letter for the tooth treated (01-32 or A-T). NOTE: When billing procedures involving quadrants, indicate the quadrant location in this Field by using the appropriate indicator. Arch locations are also to be entered in this Field if applicable. **NOTE: Effective 6/1/05 use numeric quadrant codes and arch codes listed below.**

	New Code	**Previous Code**	**Descriptor**
	01	UA	Maxillary Arch
	02	LA	Mandibular Arch
	10	UR	Upper Right Quadrant
	20	UL	Upper Left Quadrant
	30	LL	Lower Left Quadrant
	40	LR	Lower Right Quadrant
	Supernumerary extractions/impactions are to be billed using tooth numbers 33 forward and the applicable extraction/impaction procedure code.		
28	**Tooth Surface**		
	Enter the appropriate surfaces for the tooth treated on this line (for example, M, O, D, B, L, F, I).		
29	**Procedure Code**		
	Enter the procedure code which identifies the service performed.		
30	**Description**		
	Enter a brief description of the service provided to the member.		
31	**Fee**		
	On each line, enter the total usual and customary charge for the service listed on that line. Do not enter the dollar sign ($).		
32	**Other Fee(s)**		
	Enter the amount received from other insurance sources billed on this claim to be deducted. Do not enter if other source of payment was KY Medicaid or Medicare. If you have not received a payment, leave this field blank.		
33	**Total Fee**		
	Enter the total of all charges listed in field 31. Do not enter the dollar sign ($).		
35	**Remarks**		
	Enter the Referring Provider NPI and taxonomy, if applicable. This information should be left justified in this field.		

	Enter remarks when a procedure requires review: • ***Gingivectomy-*** drug induced, congenital or hereditary • ***Limited Oral Evaluation*** - fractured teeth, soft tissue trauma, accident related or any unusual circumstance • ***Exposure of an unerupted or impacted tooth for orthodontic reasons***- soft tissue, partially bony or full bony
38	**Place of Treatment**
	Enter the two digit code from the list below that identifies where the service was performed. Enter the two digit code in the box marked "other", even if the service was performed in the office. ***See Appendix F**
40	**Is Treatment for Orthodontics?**
	If treatment is for orthodontic purposes (that is exposure of tooth, banding and so on) mark yes.
45	**Treatment Resulting From**
	If treatment is a direct result of an accident, enter an "X" in the appropriate block, and enter a brief description in the remarks field (35).
46	**Date of Accident**
	If treatment is a direct result of an accident, enter the date of the accident.
48	**Name, Address, City, State**
	Enter the Provider's name and address where a claim is to be returned.
49	**NPI**
	Enter the NPI Number of the clinic, if applicable.
52A	**Additional Provider ID**
	Enter the Taxonomy Number of the clinic, if applicable.
54	**NPI**
	Enter the Rendering Provider's NPI Number.
56	**Address, City, State, Zip**
	Enter the address of the rendering provider including zip code.

56A	**Taxonomy**
	Enter the Rendering Provider's Taxonomy Number.
57	**Phone Number**
	Enter the provider's telephone number.

7 Prior Authorization Guide

The Orthodontic program provides specific services to KY Medicaid members. Coverage is specifically for members requiring orthodontic treatment, when medically necessary, to correct handicapping malocclusions. All services through this program are reviewed by orthodontic consultants to verify medical necessity.

7.1 Initial Submission

When submitting an "Initial Request" the following information must be provided:

- MAP-9: Prior Authorization Form
    - D8660 - Record/Consultation Fee
    - D8670 - Fee for Fixed Appliance Therapy (full fee)
- MAP-9A: Provider Agreement (must be signed by provider)
- MAP-396: Orthodontic Evaluation Form
- Cephalometric X-ray (with tracing)
- Panoramic X-ray
- Models - properly occluded and trimmed, carefully wrapped
- External facial pictures - frontal and profile views
- Intraoral picture - frontal, right, and left lateral views
- Members whose cases require any orthographic surgical procedures must have been referred to an oral surgeon for an oral surgery pre-treatment work-up and the resulting oral surgery work-up notes must be in the initial submission.

NOTE: All the above mentioned items must be submitted in the same package.

- All records need to be current, within the prior six months, labeled with patient's first and last name. The provider's name must also be present.
- Pictures, X-rays and treatment plans must be clear and readable.
- The prior authorization begin date is the Record/Examination date on the MAP-396. Upon review by Orthodontic consultant, if all criteria and guidelines are met, two-thirds (2/3) of the maximum allowable fee are approved.

NOTE: After receiving Orthodontic authorization and banding has been initiated, send a completed claim form to DXC Technology with two-thirds (2/3) of the provider's total fee for records. Regarding PA Forms: These forms require a delegated or authorized signature, with the exception of the MAP9A, which must be signed by the provider. Stamped signatures are not accepted.

7.2 Six Month Progress Report

When the provider requests a prior authorization for a Six Months Progress Report, the following information is required:

- MAP-559: Six Month Orthodontic Progress Report
- MAP-9: Prior Authorization Form

Procedure code D8999- fee is one-third of the provider's total treatment fee. Each visit needs to be summarized in a brief but detailed manner. The simple use of the term "adjustment" is not acceptable. The progress report should be submitted after six months of active treatment has been completed. The month after banding date is considered the first active treatment month. After receiving authorization, submit completed claim form to DXC Technology with one-third of provider's total fee.

NOTE: Submissions for prior authorization or the final third of payment should be made no less than six months and no more than 12 months after the banding date of service. Monthly visits are to be no less than three weeks in frequency.

Procedure code D8999 can be approved if all criteria and guidelines have been met after review by the Orthodontic consultant. The approved amount is one-third of the maximum allowable fee. The prior authorization begin date is the banding date on the MAP-559.

7.3 Final Case Submissions

"If member is enrolled with a managed care region on date of final records, final records must be submitted to the member's partnership"

Final case submissions consist of the following:

MAP-700	Orthodontic Final Case Submission Form Description of completed treatment. Was treatment completed according to treatment plan? If the treatment plan was modified, explain why.
MAP-9	Prior Authorization for Health Services (if billing for final records)
Beginning records (including models)	
Ending records (including models)	
Member must be under 21 years of age and KY Medicaid eligible to be paid for procedure code D8660 record fee. The date of service is the finished date on the MAP-700 form.	

If all criteria and guidelines are met, final records may be approved for date of service. This procedure code is limited to one per 12 months per member.

7.4 Fixed and removable appliance therapy

The following prior authorization information shall be submitted:

- MAP 396, KY Medicaid Orthodontic Form,
- MAP 9, Prior Authorization for Health Services,
- A panoramic film or intra-oral complete series; and
- Dental models.

7.5 Temporomandibular Joint (TMJ) Therapy

When a provider submits a Temporomandibular Joint Assessment Form, the following information must be present:

MAP-306	Temporomandibular Joint Assessment Form
MAP-9	Prior Authorization for Health Services
Member must be under 21 years of age and KY Medicaid eligible on the date of splint placement.	

Based on information received from the provider, online history files, and DMS guidelines, a decision is made to approve or deny the request.

NOTE: This procedure is limited to one per member, per lifetime.

7.6 Transmittal Methods

All prior authorization requests for Comprehensive Orthodontic Treatment, Appliance Therapy and TMJ therapy must be submitted to:

Carewise Health, Inc.
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

Request sent via UPS or Federal Express should use the following address:

Carewise Health, Inc.
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

7.7 Periodontal scaling and root planning

The following are required for prior authorization of periodontal scaling and root planning:

Periodontal charting of pre-operative depths,

MAP 9, Prior Authorization for Health Services form. Please include on the MAP-9 form, name and address of the member. If applicable, please include the name of the parent or responsible party and address.

If necessary, the consultant may request a copy of the periapical film or bitewing x-ray.

7.8 Panoramic X-rays for ages 5 and under

Letter of medical necessity

MAP-9, Prior Authorization for Health Services form. Please include on the MAP-9 form, name and address of the member. If applicable, please include the name of the parent or responsible party and address.

7.9 Prior Authorization Forms

- MAP-9 – Prior Authorization for Health Services,
- MAP-9A - Kentucky Medicaid Program Orthodontic Services Agreement,
- MAP-396 - Kentucky Medicaid Orthodontic Evaluation Form,
- MAP-559 - Kentucky Medicaid Six Month Orthodontic Progress,
- MAP-700 - Kentucky Medicaid Program Orthodontic Final Case Submission,
- MAP-556 - Kentucky Medical Assistance Program Orthodontic Referral Form,
- MAP-306 - TMJ Assessment Form.

MAP - 9A (Rev. I2/95)

KENTUCKY MEDICAID PROGRAM ORTHODONTIC SERVICES AGREEMENT

The Kentucky Medicaid Program and

_____

a participating provider of orthodontic services, mutually agree to the following:

1. Comprehensive orthodontic services have been pre-authorized for _____ a currently eligible Medicaid Member;
2. In return for an initial fee as specified by the Department for Medicaid Services, and effective upon receipt of such fee, the above-named provider agrees to provide the pre-authorized treatment as specified in the approved treatment plan:
3. If the Member moves from the initial provider's medical service area after the banding and appliances are placed, making necessary a change in providers, the initial provider agrees to submit
   a patient referral form accompanied by a letter outlining treatment status: 1) dates seen, 2) treatment given, 3) progress made with prorated fee to SHPS. This information is used by the orthodontic consultants to determine a prorated fee for the services provided;
4. As part of the aforementioned initial fee, the provider agrees to provide, at no additional cost to the Department or the Member, all retainers necessary to complete the Phase of treatment;
5. Pre-authorizations are not approved unless the Member's teeth have been properly cleaned and all general dentistry, that is, fillings, root canals, etc., have been completed;
6. If the Member or former Member fails to return for the visits, the provider must initiate three (3) written contacts, or two (2) written and two (2) verbal (telephone) contacts, with the patient and/or his/her family, to solicit the patient's return to treatment. The final contact must be by certified
   letter with the returned receipt retained in the patient record. If a patient fails to respond to the contacts, the provider is relieved of the responsibility for providing retention services unless the patient returns for such services within (6) months of the last contact by the provider;
7. The provider submits to the Medicaid Program beginning and finished records consisting of: a panoramic x-ray, a cephalometic x-ray with tracing , intraoral and extraoral facial pictures (both frontal and profile), and properly occluded and trimmed models at the conclusion of the required course of treatment Failure to submit finished records within three months after completion of treatment results in a request for recoupment of payments made to the provider. Additional measures may be made to remove the provider from the Orthodontic Program.

Signature:_____ By Agency Representative: _____
Participating Provider

Date:_____ Date: _____
License Number: _____ Title: _____

MAP-396 (REV. 03/01)

KENTUCKY MEDICAID PROGRAM
ORTHODONTIC EVALUATION FORM

Date of Records/Examination _____ Date Received _____

I. Approval_____ Disapproval _____ Total Treatment Fee_____

II. Patient Information:

A. Name _____ Birth date _____

Parent or Legal Guardian

_____

Address

_____

Telephone

_____

Sex _____ Racial/Ethnic Group

_____

B. KY Medical Assistance Card Number

_____

C. Chief Complaint

_____

D. Pertinent Medical and Dental History:

_____

_____

_____

III. Clinical Examination:

_____

_____

_____

IV. Radiographic Examination:

_____

_____

_____

V. Cast Analysis:

_____

_____

_____

VI Summary:

A. Prioritized Problem List:

_____

_____

_____

B. Treatment Plan:

_____

_____

_____

SHPS
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

MAP- 700

KENTUCKY MEDICAID PROGRAM
ORTHODONTIC FINAL CASE SUBMISSION

RECIPIENT NAME_____

MEDICAID I.D. #_____

DOCTORS NAME_____ PROVIDER #_____

DATE OF BANDING_____ FINISHED DATE_____

COPY OF BEGINNING AND FINAL RECORDS ENCLOSED- YES [ ] NO [ ]

IF NO EXPLAIN_____

WAS TREATMENT COMPLETED ACCORDING TO ORIGINAL TREATMENT PLAN

SUBMITTED ? YES [ ] NO [ ] IF NO EXPLAIN_____

_____

_____

DID THE PATIENT COMPLY WITH TREATMENT PLAN ?YES [ ] NO [ ]

IF NO EXPLAIN-_____

_____

WAS ORTHOGNATHIC SURGERY PART OF TREATMENT ? YES [ ] NO [ ]

IF YES, WHAT PROCEDURE WAS PERFORMED?_____

DOES THE PROVIDER CONSIDER THE RESULTS EXCELLENT [ ]

SATISFACTORY [ ] POOR [ ] INCOMPLETE [ ]

EXPLAIN_____

_____

PROVIDERS TOTAL FEE (FOR TREATMENT)_____

PRIOR- AUTHORIZATION NUMBER
INITIAL SUBMISSION_____
SIX MONTH REPORT_____

_____
SIGNATURE

_____
DATE

Please complete and submit for processing to the following address:

SHPS
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

MAP 559 (12-95)

KENTUCKY MEDICAID PROGRAM

SIX MONTH ORTHODONTIC PROGRESS

PATIENT IN ACTIVE TREATMENT

DATE _____

PROVIDER NAME _____ PROVIDER NUMBER_____
PROVIDER TOTAL FEE (FOR TREATMENT)_____
STREET ADDRESS_____
CITY, STATE AND ZIP_____
PHONE NUMBER_____
PATIENT'S NAME _____ M.A.I.D.#_____
PRIOR AUTHORIZATION # (INTIAL SUBMISSION)_____
BANDING DATE (START OF TREATMENT)_____
MONTH DAY YEAR

DATE	TREATMENT (SPECIFY EXACT PROCEDURE)

☐ TREATMENT IS PROGRESSING WELL AND IS ON SCHEDULE. (PLEASE LIST PATIENT VISITS ABOVE, LISTING DATE SEEN AND BRIEF DESCRIPTIONS OF TREATMENT.)

☐ TREATMENT IS BEHIND SCHEDULE. (IF CHECKED, PLEASE GIVE A BRIEF EXPLANATION OF CIRCUMSTANCES. PLEASE LIST ALL ATTEMPTS TO CONTACT PATIENT BY DATE, METHOD AND RESULT.)

DESCRIBE PROGRESS AS IT RELATES TO ORIGINAL TREATMENT PLAN.

_____
_____

ACCORDING TO MY RECORDS THE PATIENT IS:

KEEPING HIS / HER APPOINTMENTS	YES ☐	NO ☐
PRACTICING GOOD ORAL HYGIENE	YES ☐	NO ☐
TAKING CARE NOT TO BREAK THE ORTHODONTIC APPLIANCES	YES ☐	NO ☐

_____
SIGNATURE OF ORTHODONTIST

Please complete and submit for processing to the following address:

SHPS
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

MAP -556

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Orthodontic Referral Form
Patient in Active Treatment
(Please type or print.)

Date: _____

TO: _____ FROM: _____

_____

_____

Patient's Name: _____ Member Identification #: _____ Age: _____

Responsible Party: _____

Address: _____

Case Analysis and Treatment Plan: _____

Original active treatment time estimate: _____

Appliances: _____

Variations (that is torque, slot% angle, etc.): _____

_____

Date bands and/or brackets cemented: _____ Cementing medium: _____

Current Archwire Sizes: Upper: _____ Lower: _____

Headgear: Type: _____ Hours requested: _____

Intraoral elastics: _____

Size and make: _____ Hours requested: _____

Force direction: _____ Force value: _____

Removable appliance: Type: _____ Hours requested: _____

Force direction: _____ Force value: _____

Removable appliance: Type: _____ Hours requested: _____

Patient Cooperation:

Oral hygiene: _____

Headgear: _____

Elastics: _____

Appointments: _____

Patient attitude toward treatment: _____

Suggestions for Patient Motivation_____

General Remarks:

Progress to date: _____

_____

Recommendations for further treatment and/or additional comments_____

_____

Transfer of Record s:

No records were obtained: _____

Records being forwarded wider separate cover: _____

Contact our office after patient arrives and we will forward records: _____

Our records include:

Models_____ Cephalograms_____ Tracings_____ Intraoral radiographs_____ Photographs_____

Intraoral Photographs_____ Facial Photographs_____

SHPS
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

MAP-306 (REV 12/95)

TEMPOROMANDIBULAR JOINT (TMJ) ASSESSMENT FORM

PROVIDER NAME & NUMBER_____

RECIPIENT NAME & NUMBER_____

DATE OF BIRTH_____

1. What is the patient's chief complaint?_____
_____
_____

2. Describe pain associated with chief complaint?_____
_____
_____

3. What is the duration of the chief complaint?_____

4. What is the historyof the underlying chief complaint?_____
_____
_____

5. Has there been any previous treatment for the chief complaint? ( ) YES ( ) NO
If yes describe:_____
_____
_____

6. Is there pain associated with jaw functions (opening, closing, chewing, etc.) ( ) YES ( ) NO
Explain:_____
_____
_____

7. How wide can the patient open without pain? _____mm

8. How wide can the patient open maximally? _____mm

9. How far can the patient move the mandible eccentricty? Left _____ mm Right_____mm

10. Are there any TMJ sounds? ( ) YES ( ) NO If yes, at what distance during opening?
Left_____mm Right_____mm
At what distance during closing? Left _____mm Right _____mm
Is there pain associated with the joint sounds? ( ) YES ( ) NO

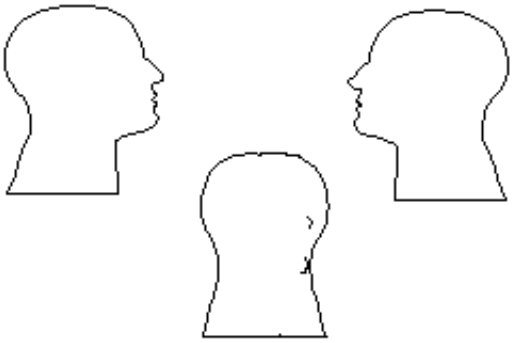
ATTENTION: Procedure D7880 is limited to recipients under the age of 21. Recipient must be Medicaid eligible and under 21 on the date of placing the splint for procedure to be covered. Providers are responsible to verify age and eligibility. NO EXCEPTIONS MADE.

11. Other medical, psychological or social factors that contribute to this condition?_____

12. What are the specific diagnosies?_____

13. What is your proprosed treatment and expected follow-up?_____

14. What is the expected cost of the treatment?_____



Place an "X" on areas that are reported painful during palpitation.

Please complete and submit for processing to the following address:

SHPS
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

7.10 Completion of the MAP-9

7.10.1 Prior Authorization for Health Services

Form MAP-9 must be submitted for procedures requiring prior authorization.

7.10.2 Detailed Instructions for Completion of MAP-9 Form

The following instructions give further direction on the completion of the MAP-9.

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	**Member Identification Number**
	Enter the member's 10 digit identification number exactly as it appears on the current Member Identification card.
2	**Member Last Name**
	Enter the last name of the member exactly as it appears on the current Member Identification card.
3	**First Name**
	Enter the first name of the member exactly as it appears on the current Member Identification card.
4	**M.I.**
	Enter the middle initial of the member.
5A	**Provider ID**
	Enter the eight digit KY Medicaid provider ID of the requesting provider.
6A	**Provider Name and Address**
	Enter the name and address of the provider making the prior authorization request.
7	**County Number of Member Residence**
	Enter the member's county of residence number.
9	**Primary Diagnosis**
	Enter the primary diagnosis.
13	**Procedure/ Supply Description**
	Enter the Quadrant or Arch code.

14	**Procedure/ Supply Code**
	Enter the appropriate procedure code.
16	**Usual and Customary Charges**
	Enter the provider's applicable fee.

The provider must sign the form and enter the date that the form is signed. The space for this information is located in the middle of the form.

MAP-9 (Rev. 02/05)	COMMONWEALTH OF KENTUCKY Cabinet for Health & Family Services KENTUCKY MEDICAID PROGRAM PRIOR AUTHORIZATION FOR HEALTH-SERVICES	

1. Med. Assist. I.D. No. Ten Digits	2. Recipient Last Name:	3. First Name:	4. M.I.
5a: Provider Number Eight Digits	6a. Provider Name, Address, and Phone Number	7. Co. # of Recipient Residence:	
5b. Provider Number Eight Digits	6b. Provider Name, Address, and Phone Number	8. Date of Delivery (if already delivered)	
9. Primary Diagnosis:		11. Date of Birth MM DD YYYY	
10. Secondary Diagnosis:			
Signature of Provider:	Date:	**Caution**: In order for you to receive payment, the recipient must be eligible on the date of service. **Check The Medicaid Card.**	

12. Line No.	13. Procedure/Supply Description	14. Procedure Supply Code	15. Units of Service	16. Usual and Customary Charges	17. Medicaid Action A=Approved D=Disapproved	18. Approved Amount*
01.						
02.						
03.						
04.						
05.						
06.						

19. HCB and Model Waiver Providers enter Approximate Total Monthly Charge:
$_____

DO NOT WRITE BELOW THIS LINE

20. Reason for Denial:

21. Other Comments:

22. Prior Authorization Number:	23. Approval Dates:	24. Type of Service Authorized:
Mailroom Use:	From: _____	40_____DME 41_____MODEL WAIVER 45_____EPSDT/SPECIAL SERVICE
	Through: _____	46_____HOME HEALTH 52_____H.C.B.
*Not used by H.C.B. Waiver/Model Waiver		52&53_____H.C.B. & A.D.C. 72_____DENTAL _____OTHER

Signature of Medicaid/Prior Authorization Representative:

Date:

Please complete and submit for processing to the following address:

Carewise Health, Inc.
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

PRIOR AUTHORIZATION RETURN TO PROVIDER LETTER

Date: _____

_____
_____
_____
_____

Dear Provider:

The enclosed Prior Authorization Request Form that you submitted cannot be processed as it appears now. Please review the area(s) indicated below that requires attention:

_____ Member's Name/Member Identification Number/Date of Birth don't match.
_____ Invalid Name, Member Identification Number, Date of Birth.
_____ Date of Birth is missing on Line 11.
_____ Invalid Provider ID.
_____ Provider Signature and Date Required.
_____ Missing or Invalid Procedure/ Diagnosis Code.
_____ Service Requested does not Match Procedure Code.
_____ Provider Signature or Date is missing or invalid on CMN/Request/Prescription.
_____ Manufacturer Product Name and Price List Required for all DME Equipment (Rental or Purchase).
_____ Attach Physical Therapist Evaluation with physical limitations of the patient.
_____ Attach Letter from MD Supporting Need for Continued Rental or Purchase of Equipment.
_____ CMN Must Include Date Last Seen by MD Prior to Equipment Request Date.
_____ "RR" Modifier must be placed on all Rental Procedure Codes.
_____ Documentation of Other Treatments Tried must be included.
_____ Banding date/Finish date is missing or invalid.
_____ Record/Examination date is missing or invalid.
_____ MAP-700 is missing from Final Case Submission.
_____ Total Treatment Fee missing.
_____ Models/X-rays/Tracings/Pictures are missing from request.
_____ MAP-9/MAP-9A/MAP-396 is missing from Initial Submission Request.
_____ MAP-9/MAP-559 missing from 6 Month Progress Report Request.
_____ Prior Authorization Number of Initial Submission or 6 Months Progress Report missing.

Other Comments: _____
_____
_____
_____

Please make the necessary additions and/or changes and resubmit for processing to the following address:

SHPS
9200 Shelbyville Rd
Suite 100
Louisville, KY 40222

Thank you.
Prior Authorization Unit

8 Appendix A

8.1 Internal Control Number (ICN)

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

11 – 10 – 032 - 123456

1 2 3 4

1. Region

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

2. Year of Receipt
3. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.
4. Batch Sequence Used Internally

9 Appendix B

9.1 Remittance Advice

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

9.1.1 Examples Of Pages In Remittance Advice

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

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

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

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

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

9.2 Title

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

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

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

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

9.3 Banner Page

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

REPORT: CRA-BANN-R
RA#: 9999999

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

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

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

Commonwealth of Kentucky

REPORT: CRA-DNPD-R | COMMONWEALTH OF KENTUCKY | DATE: 01/25/2007

RA#: 9999999 | MEDICAID MANAGEMENT INFORMATION SYSTEM | PAGE: 2

PROVIDER REMITTANCE ADVICE

DENTAL CLAIMS PAID

ACME DENTISTRY
5555 ANY STREET
SUITE 555
CITY, KY 55555-0000

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

--ICN--	RENDERING PROVIDER	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: 9999999999							
99999999999999	MCD 99999999	061206	061206	108.00	6.00	0.00	0.00	0.00	6.00

PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
11	D0150	0		061206	26.00	0.00	0125 00A1
11	D0330	0		061206	39.00	0.00	0125 00A1
11	D0274	0		061206	23.00	0.00	0125 00A1
11	D0220	6		061206	8.00	0.00	0125 00A1
11	D0230	8		061206	6.00	0.00	0125 00A1
11	D0230	10		061206	6.00	6.00	

TOTAL DENTAL CLAIMS PAID:	108.00	0.00	0.00	
	6.00	0.00		6.00

9.4 Paid Claims Page

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

REPORT: CRA-DNDN-R
RA#: 9999999

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

DATE: 01/30/2007
PAGE: 6

ACME DENTISTRY
5555 ANYSTREET
SUITE 999
CITY, ST 55555-0000

PAYEE ID 61000000
NPI ID
CHECK/EFT NUMBER
ISSUE DATE

--ICN--	RENDERING PROVIDER	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JOHN DOE		MEMBER NO.: 9999999999				
9999999999999	MCD 99999999	042706	042706	288.00	175.00	0.00

HEADER EOBS: 2265 0100

PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	DETAIL EOBS
11	D2391	02	O	042706	72.00	
11	D2391	15	O	042706	72.00	
11	D2391	18	O	042706	72.00	
11	D2391	31	O	042706	72.00	

--ICN--	RENDERING PROVIDER	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: 9999999999				
9999999999999	MCD 99999999	053006	053006	505.00	375.00	0.00

HEADER EOBS: 2265 0100

PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	DETAIL EOBS
11	D2394	30	MODB	053006	116.00	
11	D2394	31	MODB	053006	116.00	
11	D2392	29	DO	053006	91.00	
11	D2393	18	OBL	053006	110.00	
11	D2391	19	B	053006	72.00	

TOTAL DENTAL CLAIMS DENIED:	793.00	550.00	0.00

9.5 Denied Claims Page

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

REPORT: CRA-DNSU-R
RA#: 9999999

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

DATE: 01/30/2007
PAGE: 21

ACME DENTISTRY
5555 ANY STREET
SUITE 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID

MEMBER NAME: JANE DOE MEMBER NO.: 9999999999

9999999999999	MCD 99999999	061206	061206	108.00	0.00	0.00	

PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	DETAIL EOBS
11	D0150	00		061206	26.00	0642 0119 0883 0018
11	D0330	00		061206	39.00	
11	D0274	00		061206	23.00	
11	D0220	06		061206	8.00	
11	D0230	08		061206	6.00	
11	D0230	10		061206	6.00	

MEMBER NAME: JANE DOE MEMBER NO.: 9999999999

9999999999999	MCD 99999999	061206	061206	108.00	0.00	0.00	

PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	DETAIL EOBS
11	D0150	00		061206	26.00	0642 0119 0883 0018
11	D0330	00		061206	39.00	
11	D0274	00		061206	23.00	
11	D0220	06		061206	8.00	
11	D0230	08		061206	6.00	
11	D0230	10		061206	6.00	

TOTAL DENTAL CLAIMS IN PROCESS:	216.00	0.00	0.00

9.6 Claims In Process Page

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

REPORT: CRA-IPPD-R
RA#: 9999999

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

DATE: 01/30/2007
PAGE: 2

PROVIDER
5555 ANY STREET
CITY, KY 55555-5555

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

--ICN--	REASON CODE
9999999999999	01

CLAIMS RETURNED: 01

9.7 Returned Claim

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

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

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

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


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

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

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

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

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

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

9.8 Adjusted Claims Page

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

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

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

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

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

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

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

9.9 Financial Transaction Page

9.9.1 Non-Claim Specific Payouts To Providers

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

9.9.2 Non-Claim Specific Refunds From Providers

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

9.9.3 Accounts Receivable

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

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

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

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

REPORT: CRA-SUMM-R
RA#: 9999999

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

DATE: 02/01/2007
PAGE: 13

PROVIDER

P O BOX 555
CITY, KY 55555-0000

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

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

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

----------EARNINGS DATA----------

PAYMENTS:			
CLAIMS PAYMENTS	130,784.46	130,784.46	4,143,010.13
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
ACCOUNTS RECEIVABLE (OFFSETS):			
CLAIM SPECIFIC:			
CURRENT CYCLE	(0.00)	(0.00)	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)	(0.00)	(44,474.35)
NON-CLAIM SPECIFIC OFFSETS	(0.00)	(0.00)	(0.00)
NET PAYMENT	130,784.46	130,784.46	4,098,535.78
REFUNDS:			
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)	(0.00)	(0.00)
OTHER FINANCIAL:			
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
VOIDS	(0.00)	(0.00)	(0.00)
NET EARNINGS	130,784.46	130,784.46	4,098,535.78

REPORT: CRA-EOBM-R
RA#: 9999999

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

DATE: 02/01/2007
PAGE: 14

PROVIDER

P O BOX 555
CITY, KY 55555-0000

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

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

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

9.10 Summary Page

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

9.10.1 Payments

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

OTHER FINANCIAL	
NET EARNINGS	The 1099 amount.

EXPLANATION OF BENEFITS

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

EXPLANATION OF REMARKS

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

EXPLANATION OF ADJUSTMENT CODE

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

EXPLANATION OF RTP CODES

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

10 Appendix C

10.1 Remittance Advice Location Codes (LOC CD)

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

A Active

B Hold Recoup - Payment Plan Under Consideration

C Hold Recoup - Other

D Other-Inactive-FFP-Not Reclaimed

E Other – Inactive - FFP

F Paid in Full

H Payout on Hold

I Involves Interest – Cannot Be Recouped

J Hold Recoup Refund

K Inactive-Charge off – FFP Not Reclaimed

P Payout – Complete

Q Payout – Set Up In Error

S Active - Prov End Dated

T Active Provider A/R Transfer

U DXC Technology On Hold

W Hold Recoup - Further Review

X Hold Recoup - Bankruptcy

Y Hold Recoup - Appeal

Z Hold Recoup - Resolution Hearing

11 Appendix D

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

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

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

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

12 Appendix E

12.1 Remittance Advice Status Code (ST CD)

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

A Active

B Hold Recoup - Payment Plan Under Consideration

C Hold Recoup - Other

D Other-Inactive-FFP-Not Reclaimed

E Other – Inactive - FFP

F Paid in Full

H Payout on Hold

I Involves Interest – Cannot Be Recouped

J Hold Recoup Refund

K Inactive-Charge off – FFP Not Reclaimed

P Payout – Complete

Q Payout – Set Up In Error

S Active - Prov End Dated

T Active Provider A/R Transfer

U DXC Technology On Hold

W Hold Recoup - Further Review

X Hold Recoup - Bankruptcy

Y Hold Recoup - Appeal

Z Hold Recoup - Resolution Hearing

13 Appendix F

13.1 Place of Service

02	Telehealth (effective date of service 1/1/18)
03	School (effective date of service 7/1/15)
04	Homeless Shelter (effective date of service 7/1/15)
11	Office
12	Home
15	Mobile Unit
16	Temporary Lodging (effective date of service 7/1/15)
17	Walk-in Retail Health Clinic (effective date of service 7/1/15)
19	Off Campus – Outpatient Hospital (Dates of service on or after 2/1/16)
20	Urgent Care Facility (effective date of service 7/1/15)
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility (effective date of service 7/1/15)
49	Independent Clinic (effective date of service 7/1/15)
50	Federally Qualified Health Center (effective date of service 7/1/15)
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
54	Intermediate Care Facility/Mentally Retarded (effective date of service 7/1/15)
55	Residential Substance Abuse Treatment Facility (effective date of service 7/1/15)
56	Psychiatric Residential Treatment Center (effective date of service

	7/1/15)
71	Public Health Clinic (effective date of service 7/1/15)
72	Rural Health Clinic (effective date of service 7/1/15)
99	Other (end dated 6/30/15)