Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions
For
Rural Health Services
Provider Type – 35

Version 5.2

October 29, 2012

Document Change Log

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TABLE OF CONTENTS

NUMBER	DESCRIPTIONS	PAGE
1	**General**	**3**
1.1	Introduction	3
1.2	Member Eligibility	3
1.2.1	Plastic Swipe KY Medicaid Card	4
1.2.2	Member Eligibility Categories	5
1.2.3	Verification of Member Eligibility	7
2	**Electronic Data Interchange (EDI)**	**9**
2.1	How To Get Started	9
2.2	Format and Testing	9
2.3	ECS Help	9
2.4	Companion Guides for Electronic Claims (837) Transactions	9
3	**KyHealth Net**	**10**
3.1	How To Get Started	10
3.2	KyHealth Net Companion Guides.	10
4	**General Billing Instructions for Paper Claim Forms**	**11**
4.1	General Instructions	11
4.2	Imaging	11
4.3	Optical Character Recognition	11
5	**Additional Information and Forms**	**12**
5.1	Claims with Dates of Service More than One Year Old	12
5.2	Retroactive Eligibility (Back-Dated) Card	12
5.3	Unacceptable Documentation	12
5.4	Third Party Coverage Information	13
5.4.1	Commercial Insurance Coverage (this does NOT include Medicare)	13
5.4.2	Documentation That May Prevent A Claim from Being Denied for Other Coverage	13
5.4.3	When there is no response within 120 days from the insurance carrier	14
5.4.4	For Accident And Work Related Claims	14
5.5	Provider Inquiry Form	16
5.6	Prior Authorization Information	18
5.7	Adjustments And Claim Credit Requests	19
5.8	Cash Refund Documentation Form	21
5.9	Return To Provider Letter	23
5.10	Provider Representative List	25
5.10.1	Phone Numbers and Assigned Counties	25
6	**Completion of Sterilization Consent Form, MAP-250**	**26**
6.1	Purpose	26
6.2	General Instructions	26
6.2.1	MAP-250 – Sterilization Consent Form	27
6.2.2	Detailed Instructions for Completion of the Consent Form	28
7	**Completion Of CMS-1500 (08/05) Paper Claim Form**	**30**
7.1	New CMS-1500 (08/05) Claim Form with NPI and Taxonomy	31
7.2	Completion of New CMS 1500 (08/05) Claim Form with NPI and Taxonomy	32
7.2.1	Detailed Instructions	32
7.3	Helpful Hints For Successful CMS-1500 (08/05) Filing	38
7.4	Mailing Information	38
7.5	Dental Claim – ADA 2006 With NPI and Taxonomy	39
7.6	Completion of Dental Claim – ADA 2006 With NPI	40
7.7	Resubmission of Medicare/Medicaid Part B Claims	44

8 Appendix A 45
8.1 Resubmission of Medicare/Medicaid Part B Claims 45
8.1.1 Medicare Coding 45
8.1.2 Medicare Coding Sheet 46
8.1.3 Medicare Coding Sheet Instructions 47

9 Appendix B 48
9.1 Internal Control Number (ICN) 48

10 Appendix C 49
10.1 Remittance Advice 49
10.1.1 Examples Of Pages In Remittance Advice 49
10.2 Title 51
10.3 Banner Page 51
10.4 Paid Claims Page 54
10.5 Denied Claims Page 56
10.6 Claims In Process Page 58
10.7 Returned Claim 60
10.8 Adjusted Claims Page 62
10.9 Financial Transaction Page 64
10.9.1 Non-Claim Specific Payouts To Providers 64
10.9.2 Non-Claim Specific Refunds From Providers 64
10.9.3 Accounts Receivable 64
10.10 Summary Page 68
10.10.1 Payments 68

11 Appendix D 72
11.1 Remittance Advice Location Codes (LOC CD) 72

12 Appendix E 73
12.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD) 73

13 Appendix F 76
13.1 Remittance Advice Status Code (ST CD) 76

1 General

1.1 Introduction

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:

http://chfs.ky.gov/dms/Regs.htm

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

http://chfs.ky.gov/dms/fee.htm

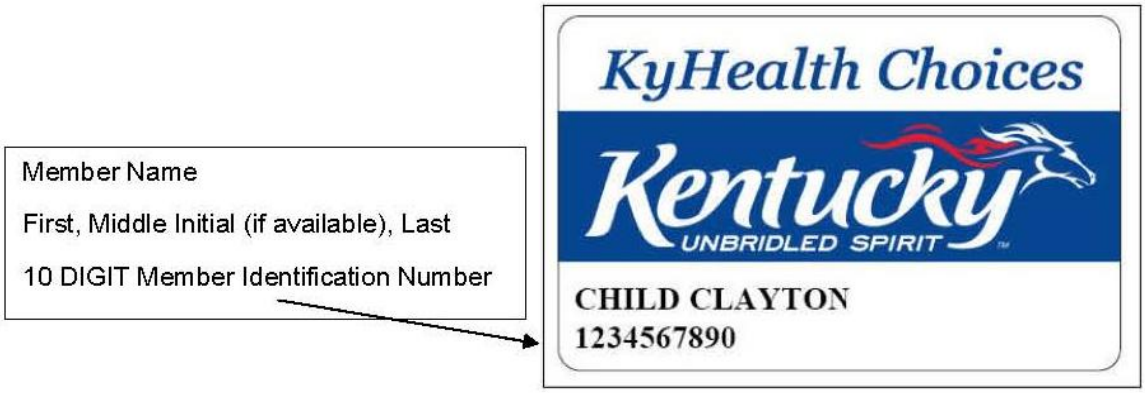
1.2 Member Eligibility

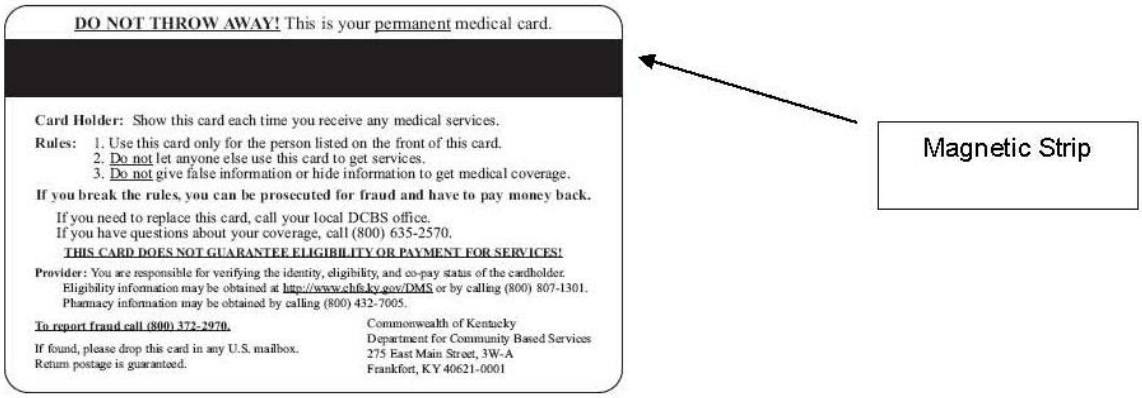
Members should apply for Medicaid eligibility through their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on Holidays.

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 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; and possession of a Member Identification card does not guarantee payment for all medical services.

1.2.1 Plastic Swipe KY Medicaid Card





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

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

1.2.2 Member Eligibility Categories

1.2.2.1 QMB and SLMB

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. A QMB Member's card shows "QMB" or "QMB Only." 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

Passport is a healthcare plan serving Kentucky Medicaid members who live in the following counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

The other Managed Care Plans servicing Kentucky Medicaid members are WellCare of Kentucky, Kentucky Spirit Health Plan and CoventryCares of Kentucky. These plans are not county regional as Passport indicated above.

Medical benefits for persons whose care is overseen by an MCO are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with Managed Care plan questions should contact: Passport Provider Services at 1-800-578-0775, WellCare of Kentucky at 1-877-389-9457, Kentucky Spirit Health Plan at 1-866-643-3153 and CoventryCares of Kentucky at 1-855-300-5528.

1.2.2.3 KCHIP

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

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

1.2.2.4 Presumptive Eligibility

Presumptive Eligibility (PE) is a program which offers pregnant women temporary medical coverage for prenatal care. A treating physician may issue an Identification Notice to a woman after pregnancy is confirmed. Presumptive Eligibility expires 90 days from the date the Identification Notice is issued, but coverage will not extend beyond three calendar months. This short-term program is only intended to allow a woman to have access to prenatal care while she is completing the application process for full Medicaid benefits.

1.2.2.4.1 Presumptive Eligibility Definitions

Presumptive Eligibility (PE) is designed to provide coverage for ambulatory prenatal services when the following services are provided by approved health care providers.

A. SERVICES COVERED UNDER PE

- Office visits to a Primary Care Provider (see list below) and/or Health Department
- Laboratory Services

- Diagnostic radiology services (including ultrasound)
- General dental services
- Emergency room services
- Transportation services (emergency and non-emergency)
- Prescription drugs (including prenatal vitamins)

B. DEFINITION OF PRIMARY CARE PROVIDER – Any health care provider who is enrolled as a KY Medicaid provider in one of the following programs:

- Physician/osteopaths practicing in the following medical specialties:
  - Family Practice
  - Obstetrics/Gynecology
  - General Practice
  - Pediatrics
  - Internal Medicine
- Physician Assistants
- Nurse Practitioners/ARNP's
- Nurse Midwives
- Rural Health Clinics
- Primary Care Centers
- Public Health Departments

C. SERVICES NOT COVERED UNDER PE

- Office visits or procedures performed by a specialist physician (those practicing in a specialty other than what is listed in Section B above), even if that visit/procedure is determined by a qualified PE primary care provider to be medically necessary
- Inpatient hospital services, including labor, delivery and newborn nursery services;
- Mental health/substance abuse services
- Any other service not specifically listed in Section A as being covered under PE
- Any services provided by a health care provider who is not recognized by the Department for Medicaid Services (DMS) as a participating provider

1.2.2.5 Breast & Cervical Cancer Treatment Program

Breast and 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 to 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 the Breast and Cervical Cancer Program are entitled to full Medicaid services. Women who are eligible through PE or BCCTP do not receive a medical card for services. The enrolling provider will give 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;
- KYHealth-Net at http://www.chfs.ky.gov/dms/kyhealth.htm
- 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)

HP Enterprise Services maintains a Voice Response Eligibility Verification (VREV) system that provides member eligibility verification, as well as third party liability (TPL) information, Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status information.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.
2. Prompt the caller to select the type of inquiry desired (eligibility, check amount, claim status, and so on).
3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

This system allows providers to take a shortcut to information. Users may key the appropriate responses (such as provider ID or Member number) as soon a 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.

The telephone number (for use by touch-tone phones only) for the VREV is 1-800-807-1301. The VREV system cannot be accessed via rotary dial telephones.

1.2.3.1.2 KYHealth-Net Online Member Verification

KYHEALTH-NET ONLINE ACCESS CAN BE OBTAINED AT:

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

The KyHealth Net website is designed to provide real-time access to member information. A User Manual is available for downloading and is designed to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the HP Enterprise Services Electronic Claims Department at KY_EDI_Helpdesk@hp.com.

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 HP Enterprise Services Electronic Data Interchange Technical Support Help Desk at:

HP Enterprise Services
P.O. Box 2016
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 HP Enterprise Services 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.

2.4 Companion Guides for Electronic Claims (837) Transactions

837 Companion Guides are available at:

http://www.kymmis.com/kymmis/Companion%20Guides/index.aspx

3 KyHealth Net

The KyHealth Net 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 KyHealth Net rather than paper claims submission. To become a KyHealthNet 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 KyHealth Net Companion Guides.

Field-by-field instructions for KyHealth Net 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 HP Enterprise Services 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 KYHealth-Net verifying eligibility issuance date and eligibility dates must be attached behind the claim;
- A screen print from KYHealth-Net 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 eligilbility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KYHealth-Net 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 HP Enterprise Services.

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 a 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 HP Enterprise Services 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 HP Enterprise Services. HP Enterprise Services 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 HP Enterprise Services with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

HP Enterprise Services
ATTN: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

5.4.4.1 TPL Lead Form

HP Enterprise Services

HP Enterprise Services
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:

HP Enterprise Services
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 HP Enterprise Services. A copy is returned with a response;
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;
- A toll free HP Enterprise Services number **1-800-807-1232** is available in lieu of using this form; and,
- To check claim status, call the HP Enterprise Services Voice Response on **1-800-807-1301**.

Provider Inquiry Form

HP Enterprise Services Corporation

Post Office Box 2100

Frankfort, KY 40602-2100

Did you know that electronic claim submission can reduce your processing time significantly? You can also check claim status, verify eligibility, download remittance advices, and many other functions. Go to www.kymmis.com or contact Billing Inquiry at 1-800-807-1232 for more information. You may also send an inquiry via e-mail at ky_provider_inquiry@hp.com

1. Provider Number	3. Member Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
7. Email	8.ICN (if applicable)	

. Provider's Message

10.

Signature Date

HP Enterprise Services Response: OFFICE USE ONLY

_____This claim has been resubmitted for possible payment.

_____This claim paid on _____in the amount of _____

_____This claim was denied on _____with EOB code_____

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

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 intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to 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 nor 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 KYHealth Net 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:

HP Enterprise Services
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.

HP Enterprise Services

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

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

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

CHECK APPROPRIATE BOX: **CLAIM ADJUSTMENT** ☐ **CLAIM CREDIT** ☐		1. Original Internal Control Number (ICN)	
2. Member Name		3. Member Medicaid Number	
4. Provider Name and Address	5. Provider	6. From Date of Service	7. To Date of Service
	8. Original Billed Amount	9. Original Paid Amount	10. Remittance Advice Date

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

_____

_____

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

_____

_____

_____

13. Signature _____ 14. Date _____

DMS Approved: January 10, 2011

5.8 Cash Refund Documentation Form

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

HP Enterprise Services
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.

HP Enterprise Services

Mail To: *HP Enterprise Services*
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 several 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 HP Enterprise Services 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.

HP

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 8-digit 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 EOMB does not match the claim
___Dates of Service _____Recipient 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 Recipient

- The Recipient's Medicaid number on the HCFA must be entered Field 9A
- The Recipient's Medicaid number on the UB92 must be entered in 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 EDS at 1-800-205-4696 7:30 AM to 6PM 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

JACKIE RICHIE 502-209-3100 Extension 2021273 jackie.richie@hp.com			VICKY HICKS 502-209-3100 Extension 2021263 vicky.hicks@hp.com			PENNY GERMINARO 502-209-3100 Extension 2021281 penny.germinaro@hp.com
Assigned Counties			Assigned Counties			Assigned Counties
ADAIR	HARLAN	MCLEAN	ANDERSON	GRAYSON	MERCER	ALLEN
BALLARD	HENDERSON	MCCREARY	BATH	GREENUP	MONTGOMERY	BARREN
BELL	HICKMAN	METCALFE	BOURBON	HANCOCK	MORGAN	BOONE
BOYLE	HOPKINS	MONROE	BOYD	HARDIN	NELSON	CAMPBELL
BREATHITT	JACKSON	MUHLENBERG	BRACKEN	HARRISON	NICHOLAS	CARROLL
BULLITT	JEFFERSON	OLDHAM	BRECKINRIDGE	JESSAMINE	OHIO	EDMONSON
CALDWELL	KNOTT	OWSLEY	BUTLER	JOHNSON	POWELL	GALLATIN
CALLOWAY	KNOX	PERRY	CARTER	LAWRENCE	ROBERTSON	GRANT
CARLISLE	LARUE	PIKE	CLARK	LEE	ROWAN	HART
CASEY	LAUREL	PULASKI	DAVIESS	LEWIS	SHELBY	HENRY
CHRISTIAN	LESLIE	ROCKCASTLE	ELLIOTT	MADISON	SPENCER	KENTON
CLAY	LETCHER	RUSSELL	ESTILL	MAGOFFIN	WASHINGTON	OWEN
CLINTON	LINCOLN	TAYLOR	FAYETTE	MARTIN	WOLFE	PENDLETON
CRITTENDEN	LIVINGSTON	TODD	FLEMING	MASON	WOODFORD	SCOTT
CUMBERLAND	LOGAN	WAYNE	FRANKLIN	MEADE		SIMPSON
FLOYD	LYON	WHITLEY	GARRARD	MENIFEE		TRIMBLE
FULTON	MARION	TRIGG				WARREN
GRAVES	MARSHALL	UNION				
GREEN	MCCRACKEN	WEBSTER				

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

6 Completion of Sterilization Consent Form, MAP-250

6.1 Purpose

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

6.2 General Instructions

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

All applicable fields must be completed.

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

- The surgeon;

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

Order MAP-250 forms from:

www.kymmis.com

6.2.1 MAP-250 – Sterilization Consent Form

MAP-250
(REV. 5/87)

CONSENT FORM

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

Press firmly to assure legible copies

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from John Smith MD (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

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

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

I understand that I will be sterilized by an operation known as a Tubal Ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on 09 27 70 (Month Day Year)

I, Jane Doe, hereby consent of my own free will to be sterilized by John Smith MD (doctor) by a method called Tubal Ligation. My consent expires 180 days from the date of my signature below.

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

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Jane Doe (Signature) Date 09-19-95 (Month Day Year)

You are requested to supply the following information, but it is not required:

(Race and ethnicity designation/please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☒ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

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

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

_____ (Interpreter) _____ (Date)

STATEMENT OF PERSON OBTAINING CONSENT

Before Jane Doe (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation Tubal Ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

John Smith M.D. (Signature of person obtaining consent) 09-19-95 (Date)

123 Lone Oak (Facility)

Derby, Kentucky 40000 (Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon Jane Doe (name of individual to be sterilized) on 10 20 95 (Date of sterilization) I explained to him/her the nature of the operation Tubal Ligation sterilization operation Tubal Ligation (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

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

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

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

- ~~☐ Premature delivery~~
- ~~☐ Individual's expected date of delivery:~~
- ~~☒ Emergency abdominal surgery~~

~~(describe circumstances):~~

John Smith M.D. (Physician) 10-20-95 (Date)

3. State Agency, Program or Project

U.S. GOVERNMENT PRINTING OFFICE: 1978 O—276-332

6.2.2 Detailed Instructions for Completion of the Consent Form

6.2.2.1 Consent to Sterilization

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

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

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

6.2.2.2 Interpreter's Statement

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

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

6.2.2.3 Statement of Person Obtaining Consent

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

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

6.2.2.4 Physician Statement

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

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

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

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

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

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

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

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

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

7 Completion Of CMS-1500 (08/05) Paper Claim Form

The CMS-1500 (08/05) claim form is used to bill services for Rural Health. A copy of a completed claim form is shown on the following page.

Providers may order CMS-1500 (08/05) claim forms from the:

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

7.1 New CMS-1500 (08/05) Claim Form with NPI and Taxonomy

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Sample Only

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

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

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

3. PATIENT'S BIRTH DATE MM DD YY: **06 24 42** SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY STATE

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

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

11. INSURED'S POLICY GROUP OR FECA NUMBER: **If other Insurance makes payment**

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **4000000000**

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: **If other Insurance makes payment**

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. **123 . 4** 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **If Applicable**

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10	01	06				11		99213	EP	1	60. 00	1	E	ZZ / NPI	Taxonomy / NPI
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

IF APPLICABLE

"Of Rendering Provider" For Both ZZ and NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: **14 DIGITS**

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

28. TOTAL CHARGE $ **60. 00**

29. AMOUNT PAID $ **If Applicable**

30. BALANCE DUE **If Applicable**

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

SIGNED DATE **01/01/2012**

32. SERVICE FACILITY LOCATION INFORMATION: **If applicable**

a. b.

33. BILLING PROVIDER INFO & PH # ( )

Your Place
100 Easy Street
Anytown, KY 40601

a. **Pay to NPI** b. **ZZ Pay to Taxonomy**

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FOLD HERE / USE ENVELOPE NO. 1500E

7.2 Completion of New CMS 1500 (08/05) Claim Form with NPI and Taxonomy

7.2.1 Detailed Instructions

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

The following fields must be completed:

FIELD NUMBER	FIELD NAME AND DESCRIPTION
2	**Patient's Name**
	Enter the Member's last name, first name and middle initial exactly as it appears on the Member Identification card.
3	**Date of Birth**
	Enter the date of birth for the member.
9A	**Other Insured's Policy Group Number**
	Enter the 10 digit number exactly as it appears on the current card.
10	**Patient's Condition**
	Required if Member's condition is related to employment, auto accident or other accident. Check the appropriate block if Member's condition relates to any of the above.
11	**Insured's Policy Group or FECA Number**
	Required only if Member has insurance in addition to Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the policy number of the other insurance. Also, complete Fields 11c and 29. **NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from carrier to the submitted claim.**
11C	**Insurance Plan Name or Program Name**
	Required only if Member has insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the name of the other insurance company. Also, complete Fields 11 and 29. **NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from carrier to the submitted claim.**
17B	**Referring Provider**
	NOTE: Any claims prior to 11/1/11 KenPAC or Lockin may be required

21	**Diagnosis or Nature of Illness or Injury**	
	Enter the appropriate ICD-9-CM diagnosis code. Use appropriate V codes for Family Planning.	
23	**Prior Authorization**	
	Enter the appropriate Prior Authorization number, if applicable, assigned by HP Enterprise Services.	
24A	**Date of Service (Non Shaded Area)**	
	Enter the date in month, day, year format (MMDDYY). Only one date of service per claim form.	
24B	**Place of Service (Non Shaded Area)**	
	Enter the appropriate two digit place of service code, which identifies the location where services were rendered. Below is a list of valid place of service codes for Rural Health Clinics:	
	11	Office
	12	Home
	21	Inpatient Hospital
	22	Outpatient Hospital
	23	Emergency Room-Hospital
	31	Skilled Nursing Facility
	32	Nursing Facility
	51	Inpatient Psychiatric Facility
	72	Rural Health Clinic
	99	Other Unlisted Facility
24D	**Procedures, Services or Supplies (Non Shaded Area)**	
	Enter the appropriate HIPAA compliant procedure code identifying the service or supply provided to the Member.	
	For Early Periodic Screening, Diagnosis and Treatment (EPSDT) procedures one of the following procedure codes must be used:	

	New Codes	**Old Codes**	
	99381 – 99385	**WP101**	Initial Complete Screening
	99391 – 99397	**WP102**	Visit Complete Screening
	End Dated	**WP111**	Initial Partial Screening
	End Dated	**WP112**	Revisit Partial Screening
	End Dated	**WP113**	Completion of a Partial Screening
	Modifiers (Non Shaded Area)		
	When billing for the right or left temple using procedure code 92499, enter modifier RT to identify the right temple and/or LT to identify the left temple in modifier field of 24D.		
	Modifier 25 should be used only with an evaluation and management (E&M) service code and only when a significant, separately identifiable evaluation and management service is provided by the same provider to the same patient on the same day of the procedure or service. Documentation is not required to be submitted with the claim but appropriate documentation for the procedure and evaluation and management service must be maintained.		
	EP- EPSDT screening FP-Family Planning for Family Planning services		
	Use 'FP' Family Planning when billing S0612 for annual gynecological examination billed with Family Planning ICD-9 diagnosis V code.		
	For Hearing Aids: Effective for Dates of Service July 1, 2006 and after, you must indicate right (RT) or left (LT) modifier ear for each Hearing Aid. (Limited to one per hearing impaired ear per every 36 months).		
24D	**Modifier (Shaded Area)**		
	Enter the appropriate disposition code to define the EPSDT service or referral.		
	Enter the appropriate EPSDT referral code, if applicable, from appendix.		
	Category	**Disposition Code** **R = Referred** **T = Treated**	
	Vision	VR, VT	

	Hearing	HR, HT
	Dental	DR, DT
	Mental Health	MR, MT
	Lead	LR, LT
	Sickle Cell	SR, ST
	Family Planning/Pregnancy	FR, FT
	Growth, Endocrine, Nutrition	GR, GT
	Cardiac	CR, CT
	Orthopedic	OR, OT
	Genito-Urinary	UR, UT
	ENT/Respiratory	ER, ET
	Neurology	NR, NT
	Hemoglobin	BR, BT
	Other	TR, TT
	Immunizations	
	DPT	ID
	Polio	IP
	MMR	IM
	HIB	IB
	Other	IO
24E	**Diagnosis Code Indicator (Non Shaded Area)**	
	Enter 1, 2, 3, or 4 when referencing the specific diagnosis for which the Member is being treated as indicated in Field 21.	
24F	**Charges (Non Shaded Area)**	
	Enter the usual and customary charge for the service being provided to the Member.	

24G	**Days or Units (Non Shaded Area)**
	Enter number of units provided for the Member on this date of service.
24I	**ID Qualifier (Shaded Area)**
	Enter a ZZ to indicate Taxonomy. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**
24J	**Rendering Provider ID # (Shaded Area)**
	Enter the Rendering Provider's Taxonomy Number. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim. The taxonomy number should correspond to the NPI entered in field 24J (Non-Shaded Area).**
24J	**(Non Shaded Area)**
	Enter the Rendering Provider's NPI Number. **NOTE: If you are billing "zero-pay" services performed by a practitioner that Kentucky Medicaid does not issue an individual provider number to (RN, LPN, Dietician, etc .); enter your facility's NPI here.**
26	**Patient Account No.**
	Enter the patient account number, if desired. HP Enterprise Services types the first 14 or fewer digits. This number appears on the remittance statement as the patient account number.
28	**Total Charge**
	Enter the total of all individual charges entered in Field 24F. Total each claim separately. **Note: fields 28, 29 and 30 on page one must be left blank when billing a two page cms-1500 (08/05) claim. Enter the combined totals from pages one and two into fields 28, 29 and 30 as applicable on page two of the two page claim.**
29	**Amount Paid**
	Enter the amount paid, if any, by a private insurance. Do not enter Medicare paid amount. Also, complete Fields 11 and 11c. **NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from the carrier to the submitted claim.**

30	**Balance Due**
	Enter only the amount received from Medicare, if any.
31	**Date**
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
32	**Service Facility Location Information**
	If the address in Form Locator 33 is not the address of where the service was rendered, Form Locator 33 must be completed.
33	**Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number**
	Enter the Rural Health provider's name, address, zip code and phone number.
33A	**NPI**
	Enter the appropriate Pay to NPI Number.
33B	**(Shaded Area)**
	Enter ZZ followed by the Pay To Taxonomy Number. **NOTE: If more than one individual Healthcare provider rendered services on the same date of service for the same Member and at a single location, a separate CMS form is required for each healthcare provider. 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.**

7.3 Helpful Hints For Successful CMS-1500 (08/05) Filing

- Any required documentation for claims processing must be attached to each claim. Each claim is processed separately.
- Be sure to include the “AS OF” date and “EOB” code when copying a remittance advice as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after four weeks from your submission date.
- Field 24B (Place of Service) requires a two digit code.
- Field 24E (Diagnosis Code Indicator) is a one digit only field.
- If any insurance other than Medicare/Medicaid makes a payment on services you are billing, complete Fields 11, 11c, 29 on the CMS-1500 (08/05) claim form.
- If insurance does not make a payment on services you are billing, attach the private insurance denial to the CMS-1500 claim form. Do not complete Fields 11, 11c, 29, on the CMS-1500 (08/05) claim form.
- When billing the same procedure code, for the same date of service, you must bill on one line indicating the appropriate units of service.
- When submitting claims for the coinsurance and/or deductible after Medicare payment, do not cut your EOMB into strips. The Medicare paid date on the EOMB must be visible and is required for processing.

If you are submitting a copy of a previously submitted claim on which some line items have paid and some denied, mark through or delete any line(s) on the claim already paid. If you mark through any lines, be sure to recompute your total charge in Field 28 to reflect the new total charge billed.

7.4 Mailing Information

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

Mail completed claims to:

HP Enterprise Services
PO Box 2101
Frankfort, KY 40602-2101

7.5 Dental Claim – ADA 2006 With NPI and Taxonomy

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

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

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: NPI of Clinic

50. License Number

51. SSN or TIN

52. Phone Number ( ) –

52A. Additional Provider ID: Taxonomy of Clinic

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 *Signature*
Signed (Treating Dentist) — Date

54. NPI: NPI rendering provider

55. License Number

56. Address, City, State, Zip Code: Provider Name, 1234 Any Street, Any Town, KY 40600

56A. Provider Specialty Code: Taxonomy rendering provider

57. Phone Number ( ) –

58. Additional Provider ID

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Sample

7.6 Completion of Dental Claim – ADA 2006 With NPI

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 Code**
	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 ($).		
30 and 31 line 10	If a TPL insurance payment has been received, enter on line 10 in field 30 the term Subtotal and on line 10 in field 31 enter the subtotal amount of charges. Do not enter the dollar sign ($).		
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**		
	Subtract the amount in the Other Fees from the Total Fee Charges and enter the remainder in this field. Do not enter the dollar sign ($).		

35	**Remarks**	
	Enter remarks when a procedure requires review that is gingivectomy, limited oral evaluation, exposure of an unerupted or impacted tooth for orthodontic reasons (that is 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.	
	Doctor's Office	11
	Patient's Home	12
	Inpatient Hospital	21
	Outpatient Hospital	22
	Ambulatory Surgical Center	24
	Nursing Facility	32
	Day Care Facility	52
	Night Care Facility	52
	Other Locations	99
40	**Is Treatment for Orthodontics?**	
	If treatment is for orthodontic purposes (that is exposure of tooth, banding, etc) 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.
53	**Signed (Treating Dentist)**
	Signature of the treating dentist and the date claim form was signed. Date can not be prior to the date of service. Stamped signatures are not accepted.
54	**NPI**
	Enter the rendering dentist's NPI Number.
56	**Address, City, State, Zip**
	Enter the address of the rendering provider including zip code.
56A	**Taxonomy**
	Enter the rendering dentist's Taxonomy Number.
57	**Phone Number**
	Enter the provider's telephone number.

7.7 Resubmission of Medicare/Medicaid Part B Claims

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

A health insurance claim form, the CMS-1500 (08/05), should be submitted to KY Medicaid when an original Medicare/Medicaid automatic crossover claim has been denied deductible or coinsurance payment by Medicaid or when the provider has received no response from Medicaid within six weeks of the Medicare adjudication date. In both of these situations, a new CMS-1500 (08/05) claim should be completed and submitted to KY Medicaid according to Medicaid guidelines. To this claim, the provider must attach the corresponding Explanation of Medicare Benefits (EOMB). A copy of the EOMB (including adjudication date and Member identification information) is accepted only in its entirety.

Out of KY providers who provide services for KY Medicaid Members must submit claims on a CMS-1500 (08/05) claim to HP Enterprise Services in KY. A copy of the EOMB from the Medicare carrier in the state where the service is provided should be attached to the claim form before payment for services may be considered.

8 Appendix A

8.1 Resubmission of Medicare/Medicaid Part B Claims

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

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

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

8.1.1 Medicare Coding

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

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

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

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

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

8.1.2 Medicare Coding Sheet

CMS1500 CROSSOVER EOMB FORM

Member Name: 1 Member ID: 2

EOMB Date: 3

Line 4 Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4 Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4 Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4 Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4 Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4 Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

8.1.3 Medicare Coding Sheet Instructions

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

9 Appendix B

9.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by HP Enterprise Services 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

10 Appendix C

10.1 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.

10.1.1 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 appear in the RA are 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.

10.2 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.

10.3 Banner Page

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

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

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


Commonwealth of Kentucky
```

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

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

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

MEMBER NAME: JANE DOE          MEMBER NO.: 9999999999
  9999999999999     060606 060606         200.00                      0.00                                        0.00
     9999999XXX                                          18.05                      0.00           2.00         16.05

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

            TOTAL CMS 1500 CLAIMS PAID:   200.00                      0.00                          0.00
                                                                18.05                      0.00                        16.05
```

10.4 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 HP Enterprise Services.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The allowed amount for Medicaid
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount collected from the member.
COPAY AMOUNT	The amount collected from the member.
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS PAID ON THIS RA	The total number of paid claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).

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

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

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

HEADER EOBS:   3015  0011

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

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

10.5 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 HP Enterprise Services.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS DENIED ON THIS RA	The total number of denied claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).

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

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

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

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

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

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

10.6 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 HP Enterprise Services.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.

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

PROVIDER                                                                          PAYEE ID              99999999
5555 ANY STREET                                                                   NPI ID
CITY, KY 55555-5555                                                               CHECK/EFT NUMBER     999999999
                                                                                  ISSUE DATE          02/02/2007

 --ICN--          REASON CODE
9999999999999       01



  CLAIMS RETURNED:  01
```

10.7 Returned Claim

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

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

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

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


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

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

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

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

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

10.8 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 HP Enterprise Services.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The amount allowed for this service.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
COPAY AMOUNT	Copay amount to be collected from member.
SPENDDOWN AMOUNT	The amount to be collected from the member.
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
PAID AMOUNT	Amount paid.

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

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

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


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

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

                            NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

                            NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

       A/R         SETUP    RECOUPED      ORIGINAL        TOTAL                    REASON
    NUMBER/ICN     DATE    THIS CYCLE      AMOUNT      -RECOUPED-    --BALANCE--   CODE

   1106           011306           0.00           22.41            0.00           22.41   92

                    TOTAL BALANCE                                                  22.41
```

10.9 Financial Transaction Page

10.9.1 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.

10.9.2 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.

10.9.3 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 providers 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                    COMMONWEALTH OF KENTUCKY (M1)                    DATE:  02/01/2007
   RA#:      9999999                 MEDICAID MANAGEMENT INFORMATION SYSTEM              PAGE:          14
                                          PROVIDER REMITTANCE ADVICE
                                            EOB CODE DESCRIPTIONS

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


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

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

10.10 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 HP Enterprise Services 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.

10.10.1 Payments

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

OTHER FINANCIAL	
NET EARNINGS	Total check 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.

11 Appendix D

11.1 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	HP Enterprise Services On Hold
W	Hold Recoup - Further Review
X	Hold Recoup - Bankruptcy
Y	Hold Recoup - Appeal
Z	Hold Recoup - Resolution Hearing

12 Appendix E

12.1 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 – HP Enterprise Services 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
SS	State Share Only
UA	HP Enterprise Services Medicare Part A Recoup
XO	Reg. Psych. Crossover Refund

13 Appendix F

13.1 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 HP Enterprise Services On Hold

W Hold Recoup - Further Review

X Hold Recoup - Bankruptcy

Y Hold Recoup - Appeal

Z Hold Recoup - Resolution Hearing