# Commonwealth of Kentucky
# KY Medicaid

# Provider Billing Instructions For Independent Laboratory Services and Radiological Services Provider Type – 37

Version 4.8

October 29, 2012

# Document Change Log

| Document Version | Date | Name | Comments |
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# TABLE OF CONTENTS


| NUMBER | DESCRIPTION | PAGE |
|---|---|---|
| **1** | **General** | **1** |
| 1.1 | Introduction | 1 |
| 1.2 | Member Eligibility | 1 |
| 1.2.1 | Plastic Swipe KY Medicaid Card | 2 |
| 1.2.2 | Member Eligibility Categories | 3 |
| 1.2.3 | Verification of Member Eligibility | 5 |
| **2** | **Electronic Data Interchange (EDI)** | **7** |
| 2.1 | How To Get Started | 7 |
| 2.2 | Format and Testing | 7 |
| 2.3 | ECS Help | 7 |
| 2.4 | Companion Guides for Electronic Claims (837) Transactions | 7 |
| **3** | **KyHealth Net** | **8** |
| 3.1 | How To Get Started | 8 |
| 3.2 | KyHealth Net Companion Guides. | 8 |
| **4** | **General Billing Instructions for Paper Claim Forms** | **9** |
| 4.1 | General Instructions | 9 |
| 4.2 | Imaging | 9 |
| 4.3 | Optical Character Recognition | 9 |
| **5** | **Additional Information and Forms** | **10** |
| 5.1 | Claims with Dates of Service More than One Year Old | 10 |
| 5.2 | Retroactive Eligibility (Back-Dated) Card | 10 |
| 5.3 | Unacceptable Documentation | 10 |
| 5.4 | Third Party Coverage Information | 11 |
| 5.4.1 | Commercial Insurance Coverage (this does NOT include Medicare) | 11 |
| 5.4.2 | Documentation That May Prevent A Claim from Being Denied for Other Coverage | 11 |
| 5.4.3 | When there is no response within 120 days from the insurance carrier | 12 |
| 5.4.4 | For Accident And Work Related Claims | 12 |
| 5.5 | Provider Inquiry Form | 14 |
| 5.6 | Prior Authorization Information | 16 |
| 5.7 | Adjustments And Claim Credit Requests | 17 |
| 5.8 | Cash Refund Documentation Form | 19 |
| 5.9 | Return To Provider Letter | 21 |
| 5.10 | Provider Representative List | 23 |
| 5.10.1 | Phone Numbers and Assigned Counties | 23 |
| **6** | **Completion of CMS-1500 Paper Claim Forms** | **24** |
| 6.1 | New CMS-1500 (08/05) Claim Form with NPI and Taxonomy | 25 |
| 6.2 | Completion of New CMS-1500 (08/05) Claim Form with NPI and Taxonomy | 26 |
| 6.2.1 | Detailed Instructions | 26 |
| 6.3 | Mailing Information | 30 |
| 6.4 | Helpful Hints for Successful CMS-1500 (08/05) Filing | 31 |
| **7** | **Forms Requirements** | **32** |
| 7.1 | Example of Certification For Induced Abortion or Induced Miscarriage Form (MAP-235) | 33 |
| 7.2 | Completion of Induced Abortion or Induced Miscarriage Form (MAP-235) | 34 |
| 7.3 | Example of Certification For Induced Premature Birth Form (MAP-236) | 35 |
| 7.4 | Completion of Certification for Induced Premature Birth Form (MAP-236) | 36 |
| **8** | **Appendix A** | **37** |
| 8.1 | Resubmission of Medicare/Medicaid Part B Claims | 37 |

8.1.1 Medicare Coding ..... 37
8.1.2 Medicare Coding Sheet ..... 38
8.1.3 Medicare Coding Sheet Instructions ..... 39

**9 Appendix B ..... 40**
9.1 Internal Control Number (ICN) ..... 40

**10 Appendix C ..... 41**
10.1 Remittance Advice ..... 41
10.1.1 Examples Of Pages In Remittance Advice ..... 41
10.2 Title ..... 43
10.3 Banner Page ..... 43
10.4 Paid Claims Page ..... 46
10.5 Denied Claims Page ..... 48
10.6 Claims In Process Page ..... 50
10.7 Returned Claim ..... 52
10.8 Adjusted Claims Page ..... 54
10.9 Financial Transaction Page ..... 56
10.9.1 Non-Claim Specific Payouts To Providers ..... 56
10.9.2 Non-Claim Specific Refunds From Providers ..... 56
10.9.3 Accounts Receivable ..... 56
10.10 Summary Page ..... 60
10.10.1 Payments ..... 60

**11 Appendix D ..... 64**
11.1 Remittance Advice Location Codes (LOC CD) ..... 64

**12 Appendix E ..... 65**
12.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD) ..... 65

**13 Appendix F ..... 68**
13.1 Remittance Advice Status Code (ST CD) ..... 68

# 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

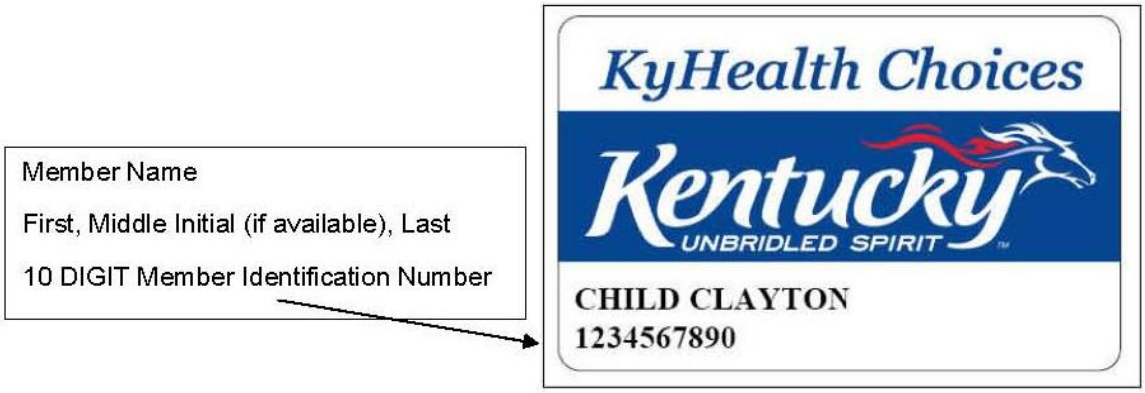
## 1.2 Member Eligibility

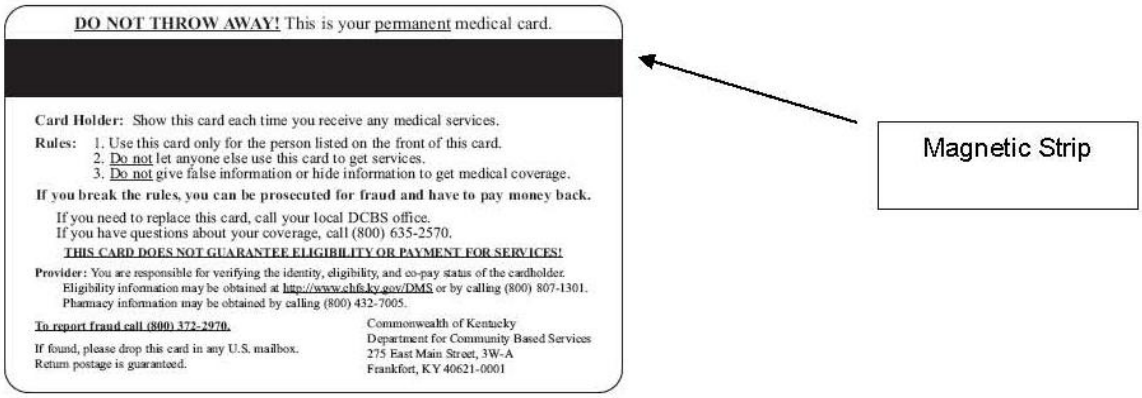
Members should apply for Medicaid eligibility through their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on Holidays.

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:**<br>**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<br>502-209-3100<br>Extension 2021273<br>jackie.richie@hp.com | | | VICKY HICKS<br>502-209-3100<br>Extension 2021263<br>vicky.hicks@hp.com | | | PENNY GERMINARO<br>502-209-3100<br>Extension 2021281<br>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 CMS-1500 Paper Claim Forms

The CMS-1500 (08/06) claim form is used to bill services for Independent Lab Services. A copy of a completed claim form is shown on the following page.

Providers may order CMS-1500 (08/06) claim forms from the:

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

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

1500

**HEALTH INSURANCE CLAIM FORM**

Sample Only

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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? 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

| | 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 | 24 | | 11719 | | | 100 00 | | IF APPLICABLE | ZZ / NPI | Taxonomy / NPI |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

"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 $ **100 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

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

### 6.2.1 Detailed Instructions

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

The following fields must be completed:

| FIELD 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 of the member. |
| **9A** | **Other Insured's Policy Group Number** |
| | Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card. |
| **10** | **Patient Condition** |
| | Required if member's condition is related to, a) employment, b) 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 other than KY 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.<br>**NOTE: If other insurance denies the claim, leave these fields blank and attach the denial statement from the carrier to the submitted claim.** |
| **11C** | **Insurance Plan Name or Program Name** |
| | Required only if member has insurance other than KY 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.<br>**NOTE: If other insurance denies the claim, leave these fields blank and attach the denial statement from the carrier to the submitted claim.** |
| **21** | **Diagnosis or Nature of Illness or Injury** |
| | Enter the appropriate ICD-9-CM diagnosis code. |

| | |
|---|---|
| **23** | **Prior Authorization Number** |
| | Enter the appropriate Prior Authorization number, if applicable.<br>**NOTE: See section 4.6 Prior Authorization for details.** |
| **24A** | **Date of Service (Non Shaded Area)** |
| | Enter the date of service. |
| **24B** | **Place of Service (Non Shaded Area)** |
| | Enter the appropriate two digit place of service code which identifies the location where services were rendered. Valid values are: 81 Independent Laboratory; 99 Other Unlisted Facility. |
| **24D** | **Procedures, Services or Supplies CPT/ HCPCS (Non Shaded Area)** |
| | Enter the appropriate HIPAA compliant HCPCS or CPT-4 procedure code identifying the service or supply provided to the member. |
| **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.<br>**NOTE: Do not enter the actual diagnosis code in this field.** |
| **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 of service provided for the member on this date of service. |
| **24I** | **ID Qualifier (Shaded Area)** |
| | Enter a ZZ to indicate Taxonomy.<br>**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.<br>**NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.** |

| | |
|---|---|
| | **(Non Shaded Area)** |
| | Enter the Rendering Provider's NPI Number. |
| **26** | **Patient's Account No.** |
| | Enter the patient account number. HP Enterprise Services types the first 14 or fewer digits. This number appears on the remittance statement as the invoice number. |
| **28** | **Total Charge** |
| | Enter the total of all individual charges entered in Field 24F. Total each claim separately. |
| **29** | **Amount Paid** |
| | Enter the amount paid, if any, by a private insurance carrier. Do not enter Medicare paid amount. Also, complete Fields 11 and 11c.<br>**NOTE: If other insurance denies the claim, leave these fields blank and attach the denial statement from the carrier to the submitted claim.** |
| **30** | **Balance Due** |
| | Required only if private insurance made payment on the claim. Subtract the private insurance payment entered in Field 29 from the total charge entered in Field 28 and enter the net balance due in Field 30. |
| **31** | **Date** |
| | Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim. |
| **32** | **Service Facility Location Information** |
| | If the address in Form Locator 33 is not the address where the service was rendered, Form Locator 32 must be completed. |
| **33** | **Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number** |
| | Enter the provider's name, address, zip code and phone number. |
| **33A** | **NPI** |
| | Enter the appropriate Pay to NPI Number. |

| 33B | (Shaded Area) |
| --- | --- |
| | Enter ZZ and the Pay To Taxonomy Number.<br><br>**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.** |

## 6.3 Mailing Information

Send the CMS-1500 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
P.O. Box 2101
Frankfort, KY 40602-2101

## 6.4 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 RA as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after four weeks from your submission date.
- Field 24B (Place of Service) requires a two digit code.
- Field 24E (Diagnosis Code Indicator) is a one digit only field.
- If any insurance other than Medicare/KY Medicaid makes a payment on services you are billing, complete Fields 11, 11c, 29 and 30 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, and 30 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.
- Do NOT check blocks for Medicare or KY Medicaid on the top of the CMS-1500 (08/05) claim form.
- 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 Forms Requirements

Forms required for reimbursement of hospital services include, but may not be limited to, the following:

- Certification for Abortion or Miscarriage (MAP-235); and,
- Certification of Premature Birth (MAP-236).

Claims and required forms completed incorrectly and submitted to KY Medicaid results in denial of payment. All forms should be completed according to KY Medicaid guidelines as outlined in the following instructions. Situations involving crossover claims from Medicare requires the UB-04 billing form, KY Medicaid required form, and EOMB for processing.

Effective for date of service July 1, 2003, hospitals no longer require the Sterilization Consent Form (MAP 250) for claims processing.

## 7.1 Example of Certification For Induced Abortion or Induced Miscarriage Form (MAP-235)

**CERTIFICATION FORM FOR INDUCED ABORTION**
**OR INDUCED MISCARRIAGE**

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

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

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

(Please check appropriate box)

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

(Please indicate date and the procedure that was performed)

_____

_____

_____

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

MAP-235 (2/00)

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

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

## 7.3 Example of Certification For Induced Premature Birth Form (MAP-236)

MAP-236 (8/78)

**CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH**

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

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

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

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

_____ of _____
(MAID #) (Address)

and/or her unborn child.

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

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

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

# 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, those services do not need to be billed to Kentucky Medicaid. The allowed amount and paid amount from Medicare would be the same.
- When writing zeros do not put a line through the zero.
- When billing a claim with multiple detail lines, be sure that Medicare has allowed a payment on those services. If Medicare has denied a detail line, that detail must be on a separate claim with the Medicare EOMB attached.
- The documents must be listed in the following order:
    - Claim form;
    - Coding sheet, and;
    - Any other attachments that may be needed.

### 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
RA#: 9999999

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

DATE: 02/01/2007
PAGE: 14

PROVIDER

P O BOX 555
CITY, KY 55555-0000

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

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

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

## 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.<br><br>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