



# **Commonwealth of Kentucky KY Medicaid**

## **Provider Billing Instructions For EPSDT Treatment Services Provider Type – 45**

Version 4.6

September 26, 2012

## Document Change Log

Document Version	Date	Name	Comments
1.0	10/12/2005	EDS	Initial creation of DRAFT Billing Instructions for EPSDT Treatment Services - PT 45
1.1	12/15/2005	HP Enterprise Services	Incorporated comments and revisions from Commonwealth.
1.2	01/18/2006	HP Enterprise Services	Replaced Provider Rep list with current list.
1.3	02/21/2006	Carolyn Stearman	Incorporated comments and revisions from Commonwealth.
1.4	04/27/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.5	05/25/2006	Tammy Delk	Updated with revisions requested by Commonwealth. v1.4 – 1.5 are actually the same as revisions were made back-to-back and no publication would have been made
1.6	08/28/2006	Ann Murray	Updated with revisions requested by Stayce Towles.
1.7	08/31/2006	Ann Murray	Updated with revisions submitted by Stayce Towles.
1.8	09/15/2006	Ann Murray	Updated with revisions submitted by Vicky Hicks.
1.9	09/18/2006	Ann Murray	Replaced Provider Representative table. v1.6 – 1.9 are actually the same as revisions were made back-to-back and no publication would have been made
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2.1	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
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2.4	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v2.0 – 2.4 are actually the same as revisions were made back-to-back and no publication would have been made
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2.9	06/11/2008	Ann Murray	Deleted without NPI and with NPI and Legacy claim and instructions.
3.0	03/09/2009	Cathy Hill	Made changes from KyHealth Choices to KY Medicaid per Stayce Towles
3.1	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept for Medicaid Services per Stayce Towles
3.2	03/30/2009	Ann Murray	Made global changes per DMS request. v3.0 – 3.2 are actually the same as revisions were made back-to-back and no publication would have been made
3.3	09/08/2009	Ann Murray	Replaced Provider Rep list.
3.4	10/21/2009	Ron Chandler	Replace all instances of “EDS” with “HP Enterprise Services”.
3.5	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @hp.com. Removed the HIPAA section. v3.4 – 3.5 are actually the same as revisions were made back-to-back and no publication would have been made
3.6	03/9/2010	Ron Chandler	Insert new provider rep list.
3.7	07/14/2010	Ron Chandler	Revise section 4.6 for PA address per Patti George email.
3.8	10/04/2010	Ann Murray	Added section 5.5 Instructions for Billing Dental Services under EPSDT
3.9	11/15/2010	Patti George Ron Chandler	Updated CMS 1500 claim form example patient birthdate year to read “01” instead of “42”.

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4.5	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
4.6	08/16/2012	Stayce Towles Patti George	Section 6- Changed Taxonomy Qualifier from PXC to ZZ in form locators 24I and 33B per CO18459. (Update of Provider Inquiry form approved by John Hoffman on 08/30/12)

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# 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>

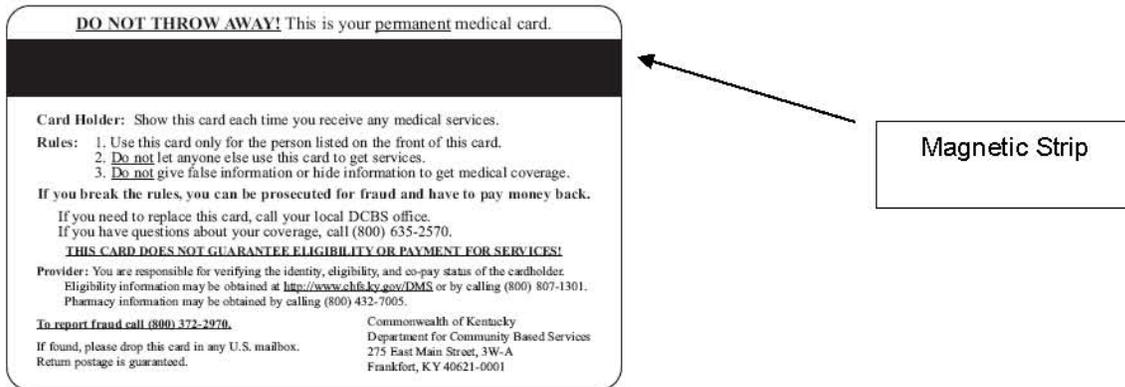
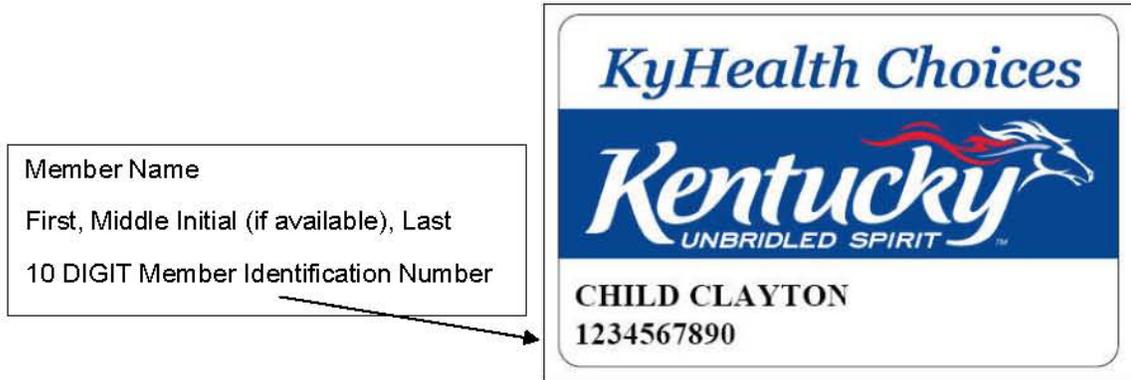
## 1.2 Member Eligibility

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 as each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and

announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

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](mailto: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.

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## 5 Additional Information and Forms

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

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

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

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or 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 eligibility 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](http://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](mailto: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.

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

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

DMS Approved: January 10, 2011

## 5.8 Cash Refund Documentation Form

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

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.



## 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.
02) PROVIDER SIGNATURE - All claims require an original signature in the provider signature block.
03) Detail lines exceed the limit for claim type.
04) UNABLE TO IMAGE OR KEY - Claim form/EOMB must be legible.
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
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

<b>JACKIE RICHIE</b> <b>502-209-3100</b> <b>Extension 2021273</b> <b>jackie.richie@hp.com</b>			<b>VICKY HICKS</b> <b>502-209-3100</b> <b>Extension 2021263</b> <b>vicky.hicks@hp.com</b>			<b>PENNY GERMINARO</b> <b>502-209-3100</b> <b>Extension 2021281</b> <b>penny.germinaro@hp.com</b>
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	DAVISS	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**

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## **6 Completion of CMS-1500 (08/05) Paper Claim Form**

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

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

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
PICA

<input type="checkbox"/> MEDICARE <small>(Medicare #)</small>	<input type="checkbox"/> MEDICAID <small>(Medicaid #)</small>	<input type="checkbox"/> TRICARE CHAMPUS <small>(Sponsor's SSN)</small>	<input type="checkbox"/> CHAMPVA <small>(Member ID#)</small>	<input type="checkbox"/> GROUP HEALTH PLAN <small>(SSN or ID)</small>	<input type="checkbox"/> FECA BLK LUNG <small>(SSN)</small>	<input type="checkbox"/> OTHER <small>(ID)</small>	1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>06 24 42</b> SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: <b>IF APPLICABLE</b>		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>If other Insurance makes payment</b>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>4000000000</b>				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>If other Insurance makes payment</b>	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE   authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
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 _____				SIGNED _____			
14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE				17b. NPI _____		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>V15 0</b> 3. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM Family Plus	
I. ID. QUAL.		J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER <b>PA# If Applicable</b>			
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196							

## 6.2 Completion of the 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
<b>2</b>	<b>Patient's Name</b>
	Enter the member's last name, first name and middle initial exactly as it appears on the Member Identification card.
<b>3</b>	<b>Date of Birth</b>
	Enter the date of birth for the member.
<b>9A</b>	<b>Other Insured's Policy Group Number</b>
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
<b>10</b>	<b>Patient's Condition</b>
	Required if member's condition is related to employment, auto accident, or other accident. Check the appropriate block if member's condition relates to any of the above.
<b>11</b>	<b>Insured's Policy Group or FECA Number</b>
	Required only if member has another insurance in addition to 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.  <b>NOTE: If other insurance denies the submitted claim, leave these fields blank and attach denial statement from carrier to the submitted claim.</b>
<b>11C</b>	<b>Insurance Plan Name or Program Name</b>
	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.  <b>NOTE: If other insurance denies the submitted claim, leave these fields blank and attach denial statement from carrier to the submitted claim.</b>

<b>14</b>	<b>Date of Current</b>
	Enter the date of illness or injury if fields 10A, 10B or 10C are marked "Yes."
<b>21</b>	<b>Diagnosis or Nature of Illness or Injury</b>
	Enter the appropriate diagnosis code.
<b>23</b>	<b>Prior Authorization Number</b>
	Enter the 10 digit prior authorization number. <b>Note: See Section 4.6 for Prior Authorization Information.</b>
<b>24A</b>	<b>Date of Service (Non Shaded Area)</b>
	Enter the date in month, day, year format (MMDDYY).
<b>24B</b>	<b>Place of Service (Non Shaded Area)</b>
	Enter the appropriate place of service. 11 – Office 12 – Home 22 – Outpatient Hospital 99 - Other
<b>24D</b>	<b>Procedures, Services or Supplies CPT/ HCPCS (Non Shaded Area)</b>
	Enter the appropriate HIPAA compliant procedure code identifying the service or supply provided to the member.
	<b>Modifier (Non Shaded Area)</b>
	<b>Note: Some procedure codes require use of modifiers for dates of service on or after 10/16/03. In some instances, 2 modifiers are required. For a list of the codes and modifiers, see Appendix F.</b>
<b>24E</b>	<b>Diagnosis Code Indicator (Non Shaded Area)</b>
	Enter 1, 2, 3, or 4 when referencing the specific diagnosis for which the member is being treated as indicated in Field 21. Do not enter the actual diagnosis code in this field. For a list of the codes and modifiers, see Appendix F.
<b>24F</b>	<b>Charges (Non Shaded Area)</b>
	Enter the usual and customary charge for the service being provided to the member.
<b>24G</b>	<b>Days or Units (Non Shaded Area)</b>
	Enter number of units provided for the member on this date of service.

<b>24I</b>	<b>ID Qualifier (Shaded Area)</b>
	Enter a ZZ to indicate Taxonomy.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>
<b>24J</b>	<b>Rendering Provider ID # (Shaded Area)</b>
	Enter the Rendering Provider's Taxonomy Number.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>
	<b>NPI (Non Shaded Area)</b>
	Enter the Rendering Provider's NPI Number.
<b>26</b>	<b>Patient's Account No.</b>
	Enter the patient account number, if desired. HP Enterprise Servicestypes the first 14 or fewer digits. This number appears on the remittance statement as the invoice number.
<b>28</b>	<b>Total Charge</b>
	Enter the total of all individual charges entered in Field 24F. Total each claim separately.
<b>29</b>	<b>Amount Paid</b>
	Enter the amount paid, if any, by a private insurance. Do not enter Medicare paid amount. Also, complete Fields 11 and 11c.  <b>NOTE: If other insurance denies the submitted claim, leave these fields blank and attach denial statement from the carrier to the submitted claim.</b>
<b>30</b>	<b>Balance Due</b>
	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.
<b>31</b>	<b>Date</b>
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.

<b>32</b>	<b>Service Facility Location Information</b>
	If the address in Form Locator 33 is not the address where the service was rendered, Form Locator 32 must be completed.
<b>33</b>	<b>Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number</b>
	Enter the provider's name, address, zip code and phone number (including area code)
<b>33A</b>	<b>NPI</b>
	Enter the appropriate Pay to NPI Number.
<b>33B</b>	<b>(Shaded Area)</b>
	Enter ZZ and the Pay To Taxonomy Number.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>

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### **6.3 Mailing Information**

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

Mail completed claims to:

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

If billing electronically, please follow the mailing instructions provided in Section 4.

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#### **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 the “AS OF” date and “EOB” code appears on the copy of any remittance advice submitted for proof of timely filing or for inquiries concerning claim status;
- Please follow up on the status of any claim that appears to be outstanding after six weeks from your submission date;
- 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; and,
- 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.



### 6.5.1 Completion of Dental Claim – ADA 2006 With NPI Version

**NOTE:** These instructions are related to the billing aspect of the dental program. For policy related issues (for example, age limitations) please refer to the Dental regulation. Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.

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

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

35	<b>Remarks</b>	
	<p>Enter remarks when a <i>procedure</i> requires review:</p> <ul style="list-style-type: none"> <li>• <b><u>Gingivectomy</u></b>- drug induced, congenital or hereditary</li> <li>• <b><u>Limited Oral Evaluation</u></b> - fractured teeth, soft tissue trauma, accident related or any unusual circumstance</li> <li>• <b><u>Exposure of an unerupted or impacted tooth for orthodontic reasons</u></b>- soft tissue, partially bony or full bony</li> </ul>	
38	<b>Place of Treatment</b>	
	<p>Enter the two digit code from the list below that identifies where the service was performed. Enter the two digit code in the box marked "other", even if the service was performed in the office.</p>	
	Doctor's Office	11
	Patient's Home	12
	Mobile Unit	15
	Inpatient Hospital	21
	Outpatient Hospital	22
	Ambulatory Surgical Center	24
	Nursing Facility	32
	Day Care Facility	52
	Night Care Facility	52
	Other Locations	99
40	<b>Is Treatment for Orthodontics?</b>	
	<p>If treatment is for orthodontic purposes (that is exposure of tooth, banding and so on) mark yes.</p>	
45	<b>Treatment Resulting From</b>	
	<p>If treatment is a direct result of an accident, enter an "X" in the appropriate block, and enter a brief description in the remarks field (35).</p>	
46	<b>Date of Accident</b>	
	<p>If treatment is a direct result of an accident, enter the date of the</p>	

	accident.
<b>48</b>	<b>Name, Address, City, State</b>
	Enter the Provider's name and address where a claim is to be returned.
<b>49</b>	<b>NPI</b>
	Enter the NPI Number of the clinic, if applicable.
<b>52A</b>	<b>Additional Provider ID</b>
	Enter the Taxonomy Number of the clinic, if applicable.
<b>53</b>	<b>Signed (Treating Dentist)</b>
	Signature of the treating dentist and the date claim form was signed. Date can not be prior to the date of service. Stamped signatures are not accepted.
<b>54</b>	<b>NPI</b>
	Enter the Rendering Provider's NPI Number.
<b>56</b>	<b>Address, City, State, Zip</b>
	Enter the address of the rendering provider including zip code.
<b>56A</b>	<b>Taxonomy</b>
	Enter the Rendering Provider's Taxonomy Number.
<b>57</b>	<b>Phone Number</b>
	Enter the provider's telephone number.

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## 7 Appendix A

### 7.1 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

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## 8 Appendix B

### 8.1 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.

#### 8.1.1 Examples Of Pages In Remittance Advice

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

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

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

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

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## 8.2 Title

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

REPORT: CRA-XBPD-R  
RA#: 9999999

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

DATE: 01/25/2007  
PAGE: 2

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

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

## 8.3 Banner Page

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

REPORT: CRA-BANN-R  
RA#: 9999999

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

DATE: 01/23/2007  
PAGE: 1

PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

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

Commonwealth of Kentucky

REPORT: CRA-BANN-R  
 RA#: 9999999

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

DATE: 01/23/2007  
 PAGE: 1

PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

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

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

TOTAL CMS 1500 CLAIMS PAID: 200.00  
 18.05 0.00 0.00 16.05

## 8.4 Paid Claims Page

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

REPORT: CRA-BANN-R 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.: 999999999		
2007017999999	060606 060606	200.00	0.00	0.00
9999999XXX				

HEADER EOB: 3015 0011

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

## 8.5 Denied Claims Page

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

REPORT: CRA-BANN-R  
 RA#: 9999999

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

DATE: 01/23/2007  
 PAGE: 1

PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

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

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

TOTAL CMS 1500 CLAIMS IN PROCESS: 200.00 0.00

## 8.6 Claims In Process Page

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

REPORT: CRA-IPPD-R  
RA#: 9999999

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

DATE: 01/30/2007  
PAGE: 2

PROVIDER  
5555 ANY STREET  
CITY, KY 55555-5555

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

--ICN-- REASON CODE  
999999999999 01

CLAIMS RETURNED: 01

**8.7 Returned Claim**

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

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

REPORT: CRA-PRAD-R  
RA#: 9999999

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

DATE: 12/14/2006  
PAGE: 2

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

PAYEE ID 99999999  
NPI ID

--ICN--	SERVICE DATES		BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID
--PATIENT NUMBER--	FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE			MEMBER NO.: 9999999999					
999999999999	031103	031103	(20.00)		(0.00)		(0.00)	
99999				(20.00)		(0.00)		(20.00)
999999999999	031103	031103	20.00		0.00		0.00	
99999				20.00		0.00		20.00
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES RENDERING		BILLED	ALLOWED	
99	WP101		1.00	FROM	THRU	AMOUNT	AMOUNT	DETAIL E OBS
				031103	031103	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.

## 8.8 Adjusted Claims Page

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

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

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

REPORT: CRA-TRAN-R  
 RA#: 9999999

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

DATE: 12/26/2006  
 PAGE: 2

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

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

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

## 8.9 Financial Transaction Page

### 8.9.1 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.

### 8.9.2 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.

### 8.9.3 Accounts Receivable

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

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

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

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

REPORT: CRA-SUMM-R  
 RA#: 9999999

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

DATE: 02/01/2007  
 PAGE: 13

PROVIDER  
 P O BOX 555  
 CITY, KY 55555-0000

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

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

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

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

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

REPORT: CRA-EOBM-R  
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.

## 8.10 Summary Page

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>CLAIMS PAID</b>	The number of paid claims processed, current month and year to date.
<b>CLAIM ADJUSTMENTS</b>	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount is followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
<b>PAID MASS ADJ CLAIMS</b>	<p>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.</p> <p>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.</p>
<b>CLAIMS DENIED</b>	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
<b>CLAIMS IN PROCESS</b>	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

### 8.10.1 Payments

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

<b>OTHER FINANCIAL</b>	
<b>NET EARNINGS</b>	Total check amount.

**EXPLANATION OF BENEFITS**

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

**EXPLANATION OF REMARKS**

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

**EXPLANATION OF ADJUSTMENT CODE**

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

**EXPLANATION OF RTP CODES**

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

## 9 Appendix C

### 9.1 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

## 10 Appendix D

### 10.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

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

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

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

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## 11 Appendix E

### 11.1 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

## 12 Appendix F

### 12.1 Local Code Crosswalk

Discontinued Codes effective Date of Service 10/16/03 and after.

<b>CODE(S)</b>	<b>DESCRIPTION</b>
W3052	REPAIR AID-COST OF MATERIALS
X0051	OTHER PROFESSIONAL OUTPATIENT GROUP
XZ100	IN HOME PNEUMOGRAM
ZR121	ROOM AND BOARD SEMI-PRIVATE TWO BED MED

Modifiers effective Date of Service 10/16/03 and after.

<b>MODIFIER</b>	<b>DESCRIPTION</b>
HE	MENTAL HEALTH PROGRAM
HF	SUBSTANCE ABUSE PROGRAM
HK	SPECIALIZED MENTAL HEALTH
RR	RENTAL
TF	INTERMEDIATE LEVEL OF CARE
TG	COMPLEX/HIGH TECH LEVEL OF CARE
TT	INDIVIDUALIZED SERVICE PROVIDED TO MORE THAN ONE PATIENT IN SAME SETTING