



# **Commonwealth of Kentucky KY Medicaid**

## **Provider Billing Instructions For Primary Care Services Provider Type – 31**

Version 5.6

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## Document Change Log

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1.0	10/14/2005	EDS	Initial creation of DRAFT Home Health Services Provider Type – 34
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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>

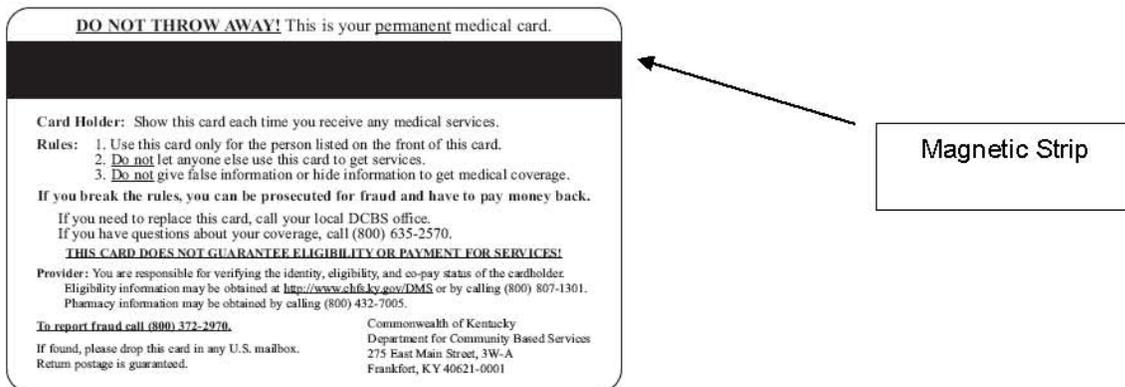
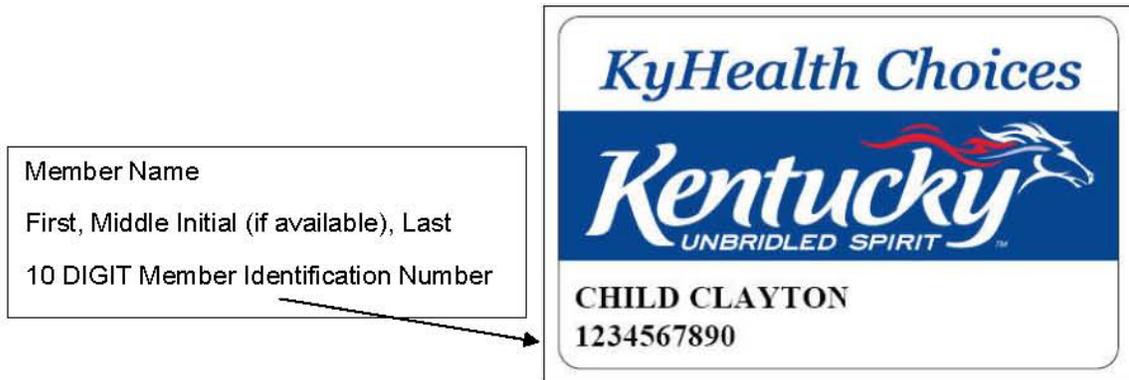
### 1.2 Member Eligibility

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

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

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

### 1.2.1 Plastic Swipe KY Medicaid Card



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

Providers who wish to 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. QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

### **1.2.2.2 Managed Care Partnership**

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

### **1.2.2.3 KCHIP**

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

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

### **1.2.2.4 Presumptive Eligibility**

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

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

- PE for pregnant women
- PE for hospitals

#### **1.2.2.4.1 PE for Pregnant Women**

##### **1.2.2.4.1.1 Eligibility**

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

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

Presumptive eligibility shall be granted to a woman if she:

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

#### **1.2.2.4.1.2 Covered Services**

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

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

- e. A physician assistant;
  - f. A certified nurse midwife; or
  - g. An advanced practice registered nurse;
2. Laboratory services;
  3. Radiological services;
  4. Dental services;
  5. Emergency room services;
  6. Emergency and nonemergency transportation;
  7. Pharmacy services;
  8. Services delivered by rural health clinics;
  9. Services delivered by primary care centers, federally-qualified health centers, and federally-qualified health center look-alikes; or
  10. Primary care services delivered by local health departments.

#### **1.2.2.4.2 PE for Hospitals**

##### **1.2.2.4.2.1 Eligibility**

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

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

##### **1.2.2.4.2.2 Covered Services**

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

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

- b. A pediatrician;
  - c. An internist;
  - d. An obstetrician or gynecologist;
  - e. A physician assistant;
  - f. A certified nurse midwife; or
  - g. An advanced practice registered nurse;
2. Laboratory services;
  3. Radiological services;
  4. Dental services;
  5. Emergency room services;
  6. Emergency and nonemergency transportation;
  7. Pharmacy services;
  8. Services delivered by rural health clinics;
  9. Services delivered by primary care centers, federally-qualified health centers and federally-qualified health center look-alikes;
  10. Primary care services delivered by local health departments; or
  11. Inpatient or outpatient hospital services provided by a hospital.

#### **1.2.2.5 Breast & Cervical Cancer Treatment Program**

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

#### **1.2.3 Verification of Member Eligibility**

This section covers:

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

### **1.2.3.1 Obtaining Eligibility and Benefit Information**

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

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

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

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

The VREV system generally processes calls in the following sequence:

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

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

#### **1.2.3.1.2 KYHealth Net Online Member Verification**

KYHealth Net online access can be obtained at <https://sso.kymmis.com>. The KYHealth Net website is designed to provide real-time access to member information. Providers can download a User Manual to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the HP Enterprise Services Electronic Claims Department at [KY\\_EDI\\_Helpdesk@hp.com](mailto:KY_EDI_Helpdesk@hp.com) or 1-800-205-4696.

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

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

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

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

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the 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.

## **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 KYHealth Net 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 provides efficient tools for claim resolution, inquiries, and attendant claim related matters.

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

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

### **4.3 Optical Character Recognition**

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

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

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

**NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by 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** or you may use the KYHealth Net by logging into <https://sso.kymmis.com>.

## 5.6 Prior Authorization Information

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

Access the 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://sso.kymmis.com>

## 5.7 Adjustments and Claim Credit Requests

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

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

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

DMS Approved: January 10, 2011

## 5.8 Cash Refund Documentation Form

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

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 NPI or 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 Coding Sheet 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 Member

- The Member's Medicaid number on the CMS 1500 (08/05) must be entered Field 9A
The Member's Medicaid number on the CMS 1500 (02/12) must be entered Field 1A
The Member's Medicaid number on the UB04 must be entered 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 HP Enterprise Services 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>KELLY GREGORY</b> <b>502-209-3100</b> <b>Extension 2021273</b> <b>Kelly.dio.gregory@hp.com</b>			<b>VICKY HICKS</b> <b>502-209-3100</b> <b>Extension 2021263</b> <b>vicky.hicks@hp.com</b>		
Assigned Counties			Assigned Counties		
ADAIR	GREEN	MCCREARY	ANDERSON	GARRARD	MENIFEE
ALLEN	HART	MCLEAN	BATH	GRANT	MERCER
BALLARD	HARLAN	METCALFE	BOONE	GRAYSON	MONTGOMERY
BARREN	HENDERSON	MONROE	BOURBON	GREENUP	MORGAN
BELL	HICKMAN	MUHLENBERG	BOYD	HANCOCK	NELSON
BOYLE	HOPKINS	OWSLEY	BRACKEN	HARDIN	NICHOLAS
BREATHITT	JACKSON	PERRY	BRECKINRIDGE	HARRISON	OHIO
CALDWELL	KNOX	PIKE	BULLITT	HENRY	OLDHAM
CALLOWAY	KNOTT	PULASKI	BUTLER	JEFFERSON	OWEN
CARLISLE	LARUE	ROCKCASTLE	CAMPBELL	JESSAMINE	PENDLETON
CASEY	LAUREL	RUSSELL	CARROLL	JOHNSON	POWELL
CHRISTIAN	LESLIE	SIMPSON	CARTER	KENTON	ROBERTSON
CLAY	LETCHER	TAYLOR	CLARK	LAWRENCE	ROWAN
CLINTON	LINCOLN	TODD	DAVISS	LEE	SCOTT
CRITTENDEN	LIVINGSTON	TRIGG	ELLIOTT	LEWIS	SHELBY
CUMBERLAND	LOGAN	UNION	ESTILL	MADISON	SPENCER
EDMONSON	LYON	WARREN	FAYETTE	MAGOFFIN	TRIMBLE
FLOYD	MARION	WAYNE	FLEMING	MARTIN	WASHINGTON
FULTON	MARSHALL	WEBSTER	FRANKLIN	MASON	WOLFE
GRAVES	MCCRACKEN	WHITLEY	GALLATIN	MEADE	WOODFORD

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

## **6 Completion of Sterilization Consent Form, MAP-250**

### **6.1 Purpose**

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

### **6.2 General Instructions**

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

All applicable fields must be completed.

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

- The surgeon.

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

Order MAP-250 forms on the website:

<http://www.kymmis.com>

### 6.3 Sterilization Consent Form (MAP-250)

MAP-250  
(REV. 5/87)

#### CONSENT FORM

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

##### ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from John Smith MD When I first asked for

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

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

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

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

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

I am at least 21 years of age and was born on 09 27 70

I, Jane Doe, hereby consent of my own free will to be sterilized by John Smith MD

by a method called Tubal Ligation. My consent expires 180 days from the date of my signature below.

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

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

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

I have received a copy of this form.

Jane Doe Signature Date 09-19-95

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

- Race and ethnicity designation (please check)
- American Indian or Alaska Native
  - Black (not of Hispanic origin)
  - Asian or Pacific Islander
  - Hispanic
  - White (not of Hispanic origin)

##### ■ INTERPRETER'S STATEMENT ■

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

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

\_\_\_\_\_  
Interpreter Date

##### ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before Jane Doe signed the

consent form, I explained to him/her the nature of the sterilization operation Tubal Ligation. The fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

John Smith MD 09-19-95  
Signature of person obtaining consent Date

Derby, Kentucky 40000  
Facility Address

##### ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon Jane Doe on 10 20 95

I explained to him/her the nature of the sterilization operation Tubal Ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

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

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

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

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

(describe circumstances):

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

Press firmly to assure legible copies

### 3. State Agency, Program or Project

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

## **6.4 Detailed Instructions for Completion of the Consent Form**

### **6.4.1 Consent to Sterilization**

The MAP-250 Form must be completed at least 30 days prior to the sterilization procedure, except in cases of premature delivery and emergency abdominal surgery, in which case a 72 hour waiting period is required.

No more than 180 days should elapse between the date the form is signed and the procedure is performed.

- 1: Enter the name of the physician, clinic or the name of the physician and the phrase “and/or associates” who expects to perform the procedure.
- 2: Enter the name of the procedure to be performed.
- 3: Enter the birth date of the Member.
- 4: Enter the name of the Member.
- 5: Enter the name of the physician expected to perform the procedure.
- 6: Enter the method of sterilization.
- 7 & 8: The Member must be 21 yrs. of age, sign and date the form (no typed dates are accepted).

Race and ethnicity information may be designated by checking the appropriate block but is not mandatory.

### **6.4.2 Interpreter’s Statement**

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

- 8A: Enter the language used to read and explain the form.
- 8B: The interpreter must sign and date the form.

### **6.4.3 Statement of Person Obtaining Consent**

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

- 9: Enter the Member’s name.
- 10: Enter the procedure name.
- 11. &12: The person obtaining the consent must read, sign and date the form. The date must be on or after the date the Member signed.
- 13. & 14: Enter the name and address of the facility or office of the person obtaining consent.

### **6.4.4 Physician Statement**

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

1. Enter the name of the Member and date of the sterilization.

2. Enter the procedure performed.
3. Follow instructions on the form. Cross out the paragraphs not used.
  - If the sterilization was performed less than 30 days but more than 72 hours after date of the individual's signature and date on the consent form, check the applicable block and provide the information requested.
  - In the case of premature delivery, enter the expected date of delivery. The expected date of delivery should be at least 30 days after the individual's signature and date.
  - If the procedure was performed as the result of emergency abdominal surgery, enter a brief description in the designated area of the consent form or attach an operative report to describe the circumstances.
4. The physician(s) who performed the procedure must sign the form in this section.
5. Enter the date the physician signed the form. This date must be on or after the date of the surgery.

## **7 Completion of CMS-1500 Paper Claim Form**

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

Providers may order CMS-1500 claim forms from the following:

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

7.1 CMS-1500 (02/12) Claim Form with NPI and Taxonomy



**HEALTH INSURANCE CLAIM FORM**

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

PICA												PICA					
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)					000000000					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
Doe, John						01 01 1990		M									
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)							
						Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
CITY			STATE			8. RESERVED FOR NUCC USE					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						a. EMPLOYMENT? (Current or Previous)					a. INSURED'S DATE OF BIRTH						
IF OTHER INSURANCE MAKES PAYMENT						<input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)					MM DD YY M F						
b. RESERVED FOR NUCC USE											b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE											c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. INSURANCE PLAN NAME OR PROGRAM NAME											d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
IF OTHER INSURANCE MAKES PAYMENT											<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>						
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.												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 _____ DATE _____												SIGNED _____					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)				15. OTHER DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
MM DD YY QUAL				MM DD YY QUAL				FROM MM DD YY TO MM DD YY				FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____						17b. NPI _____					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9												22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					
A. 12345 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												23. PRIOR AUTHORIZATION NUMBER IF APPLICABLE					
24. A. DATE(S) OF SERVICE From To		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPOSIT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
MM DD YY MM DD YY				CPT/HCPCS MODIFIER				\$60 00	1	E	ZZ	XYZ9990000					
05 24 13 05 24 13		11		99213							NPI	1234567890					
1												NPI		Of "Rendering Provider" for both ZZ and NPI			
2												NPI					
3												NPI					
4												NPI					
5												NPI					
6												NPI					
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO. 14 DIGITS		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE \$80 00		29. AMOUNT PAID \$ IF APPLICABLE		30. Rsvd for NUCC Use				
							<input type="checkbox"/> YES <input type="checkbox"/> NO										
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.)						32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH #								
SIGNED <i>Ralph Smidlap</i> DATE 10/01/13						If Applicable			Your Place 100 Broadway Anytown, KY 40000								
						a. _____ b. _____			a. IPay to NPI		b. ZZ Taxonomy						

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

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

### 7.2.1 Detailed Instructions

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

The following fields must be completed:

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

<b>17B</b>	<b>Referring Provider</b>	
	<b>Note: Any claims prior to 11/1/11 KenPAC or Lockin may be required</b>	
<b>21</b>	<b>Diagnosis or Nature of Illness or Injury</b>	
	Enter a 9 in the ICD Indicator field in the upper right corner. Enter the required, appropriate ICD-9-CM diagnosis code. Twelve diagnosis codes may be entered.	
<b>23</b>	<b>Prior Authorization</b>	
	Enter the appropriate Prior Authorization number, if applicable, assigned by HP Enterprise Services.	
<b>24A</b>	<b>Date of Service (Non-Shaded Area)</b>	
	Enter the date in month, day, year format (MMDDYY). Only one date of service per claim form.	
<b>24B</b>	<b>Place of Service (Non-Shaded Area)</b>	
	Enter the appropriate two digit place of service code, which identifies the location where services were rendered. Below is a list of valid place of service codes for Rural Health Clinics:	
	<b>11</b>	Office
	<b>12</b>	Home
	<b>21</b>	Inpatient Hospital
	<b>22</b>	Outpatient Hospital
	<b>23</b>	Emergency Room-Hospital
	<b>31</b>	Skilled Nursing Facility
	<b>32</b>	Nursing Facility
	<b>51</b>	Inpatient Psychiatric Facility
	<b>72</b>	Rural Health Clinic
	<b>99</b>	Other Unlisted Facility

<b>24D</b>	<b>Procedures, Services or Supplies (Non-Shaded Area)</b>	
	Enter the appropriate HIPAA compliant procedure code identifying the service or supply provided to the Member.	
	For Early Periodic Screening, Diagnosis and Treatment (EPSDT) procedures one of the following procedure codes must be used:	
	<b>New Codes</b>	<b>Description</b>
	<b>99381-99385</b>	<b>Initial Complete Screenings</b>
	<b>99391-99397</b>	<b>Visit Complete Screenings</b>
<b>24D</b>	<b>Modifiers (Non-Shaded Area)</b>	
	When billing for the right or left temple using procedure code 92499, enter modifier RT to identify the right temple and/or LT to identify the left temple in modifier field of 24D.	
	Modifier 25 should be used only with an evaluation and management (E&M) service code and only when a significant, separately identifiable evaluation and management service is provided by the same provider to the same patient on the same day of the procedure or service. Documentation is not required to be submitted with the claim but appropriate documentation for the procedure and evaluation and management service must be maintained.	
	EP- EPSDT screening	
	FP-Family Planning for Family Planning services	
	Use 'FP' Family Planning when billing S0612 for annual gynecological examination billed with Family Planning ICD-9 diagnosis V code.	
	For Hearing Aids: Effective for Dates of Service July 1, 2006 and after, you must indicate right (RT) or left (LT) modifier ear for each Hearing Aid. (Limited to one per hearing impaired ear per every 36 months)	
	<b>Modifier (Shaded Area)</b>	
	Enter the appropriate disposition code to define the EPSDT service or referral.	
	Enter the appropriate EPSDT referral code, if applicable, from appendix.	
	<b>Category</b>	<b>Disposition Code</b>
	<b>R=Referred</b>	
	<b>T=Treated</b>	

<b>Vision</b>	<b>VR, VT</b>
<b>Hearing</b>	<b>HR, HT</b>
<b>Dental</b>	<b>DR, DT</b>
<b>Mental Health</b>	<b>MR, MT</b>
<b>Lead</b>	<b>LR, LT</b>
<b>Sickle Cell</b>	<b>SR, ST</b>
<b>Family Planning/Pregnancy</b>	<b>FR, FT</b>
<b>Growth, Endocrine, Nutrition</b>	<b>GR, GT</b>
<b>Cardiac</b>	<b>CR, CT</b>
<b>Orthopedic</b>	<b>OR, OT</b>
<b>Genito-Urinary</b>	<b>UR, UT</b>
<b>ENT/Respiratory</b>	<b>ER, ET</b>
<b>Neurology</b>	<b>NR, NT</b>
<b>Hemoglobin</b>	<b>BR, BT</b>
<b>Other</b>	<b>TR, TT</b>
<b>Immunizations</b>	
<b>DPT</b>	<b>ID</b>
<b>Polio</b>	<b>IP</b>
<b>MMR</b>	<b>IM</b>
<b>HIB</b>	<b>IB</b>
<b>Other</b>	<b>IO</b>
<p>Enter the appropriate HIPAA compliant two digit modifier, if applicable, that further describes the rendering provider. Modifiers accepted by Medicaid are:</p>	
<b>U4</b>	<p>For services rendered by a LP's associate, LPA; or services rendered by a LPCC's associate, LPCA; or services rendered by a LMFT's associate, LMFTA, the U4 modifier must be used to indicate that the LP/LPCC/LMFT is billing for the service rendered by his/her associate.</p>

<b>24E</b>	<b>Diagnosis Code Indicator</b>
	Enter the diagnosis pointers A-L to refer to a diagnosis code in field 21. Do not enter the actual ICD-9-CM diagnosis code.
<b>24F</b>	<b>Charges (Non-Shaded Area)</b>
	Enter the usual and customary charge for the service being provided to the Member.
<b>24G</b>	<b>Days or Units (Non-Shaded Area)</b>
	Enter number of units 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. The taxonomy number should correspond to the NPI entered in field 24J (Non-Shaded Area).</b>
<b>24J</b>	<b>(Non-Shaded Area)</b>
	Enter the Rendering Provider's NPI Number.  <b>NOTE: If you are billing "zero-pay" services performed by a practitioner that Kentucky Medicaid does not issue an individual provider number to (RN, LPN, Dietician, etc. . .); enter your facility's NPI here.</b>
<b>26</b>	<b>Patient Account No.</b>
	Enter the patient account number, if desired. HP Enterprise Services types the first 14 or fewer digits. This number appears on the remittance statement as the patient account number.
<b>28</b>	<b>Total Charges</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 9, 9A and 9D.  <b>NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from the carrier to the submitted claim.</b>
<b>31</b>	<b>Date</b>
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
<b>32</b>	<b>Service Facility Location Information</b>
	If the address in Form Locator 33 is not the address of where the service was rendered, Form Locator 32 must be completed.
<b>33</b>	<b>Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number</b>
	Enter the Primary Care provider's name, address, zip code and phone number.
<b>33A</b>	<b>NPI</b>
	Enter the appropriate Pay to NPI Number.
<b>33B</b>	<b>(Shaded Area)</b>
	Enter ZZ followed by the Pay To Taxonomy Number.
	<b>NOTE: If more than one individual Healthcare provider rendered services on the same date of service for the same Member and at a single location, a separate CMS form is required for each healthcare provider. Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>

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

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

### 7.4 Mailing Information

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

Mail completed claims to:

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

**7.4.1 Modifiers Effective For Date of Service 10/16/03 And After**

<b>Modifier</b>	<b>Description</b>
<b>EP</b>	EPSDT
<b>FP</b>	Family Planning Program
<b>LT</b>	Left Side
<b>RT</b>	Right Side

<b>Local Code</b> <b>Date of Service Prior to 10/16/03</b>	<b>DESCRIPTION</b>	<b>New Code</b> <b>Effective Date of Service 10/16/03 and after</b>	<b>New Code Description</b>	<b>Modifier</b>	<b>Comments</b>
V5000	BASIC AUDIOLOGIC ASSESSMENT - HEARING AS	92557	Comprehensive hearing test		
W0030	SIX-MONTH CHECK-UP	V5011	Hearing aid fitting/checking		
W0073	EARMOLD	V5264	Ear mold/ insert		
W0074	BATTERY	V5266	Battery for hearing device		
W0075	ADAP HEARING AID WITH BONE OSCILLATOR/HE	V5299	Hearing services		
W0080	PROF FEE-REPLACE CORD-AID	V5267	Hearing aid supply/ accessory		
W0090	PROF FEE-REPAIR OF AID	V5014	Hearing aid repair/ modifying		
W0091	HINGE REPAIR	V2799	MISCELLANEOUS VISION SERVICE	RT, LT	
W0093	TEMPLE ONLY(1)	92499	repair & adjust spectacles	RT, LT	

W0094	FRONT ONLY	92499	Eye service or procedure		
WP101	EPSDT INITIAL SCREENING	99381-99385	Prev visit initial	EP	
WP102	EPSDT REVISIT COMPLETE SCREENING	99391- 99395	Prev visit, established	EP	
X0024	SUPPLY ONLY FOAM	99429	unlisted preventive services		
X0025	SUPPLY ONLY RHYTHM	99429	unlisted preventive services		
X0029	SUPPLY ONLY OTHER SPECIFY	99429	unlisted preventive services		
X1100	IN VIS NON DISPENS THIS VISIT	99201- 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.0 OR V25.09
X1110	INITIAL EXAM WITH BIRTH CONTROL PILLS	99201- 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.01
X1120	INIT VISIT INTRAUTERINE DEUIC	99201 – 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.1
X1130	INITIAL VISIT DIAPHRAGM	99201- 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02

X1140	INITIAL VISIT FOAM	99201 – 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02
X1170	INITIAL VISIT INJECTION	99201 – 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02
X1180	REF FOR STERILIZATION W/INIT	99201 – 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02
X1190	INITIAL VISIT OTHER SPECIFY	99201 – 99205	Office/outpatient visit, new	FP	NEW PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09
X1200	FOL-UP VI PEL EX N DIS TH VIS	99211 –99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.0 OR V25.09
X1210	FOLLOW-UP V PEL EXAM B CON PI	99211– 99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.41
X1220	FOL-UP VIS PEL EX INTRAU DEVI	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.42

X1230	FOL-UP VIS PEL EX DIAPHRAGM	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.4
X1240	FOL-UP VIS PELV EXAM FOAM	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.4
X1280	REF-STERIL-FOLLOW-UP-WITH PEL	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09
X1290	FOL-UP VIS PEL EX OTHER SPECI	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09
X1300	FOL-UP VI W/O PEL EX N DI T V	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.0 OR V25.09
X1310	FOL-UP VIS W/O PEL EX B CO PI	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.41
X1320	FOL-UP VIS W/O PEL EX INTR DE	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V24.42

X1330	DIAPHRAGM-FOLLOW-UP-WITHOUT PEL	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.4
X1340	FOL-UP VIS W/O PELV EXAM FOAM	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.4
X1360	RHYTHM FOLLOW UP WITHOUT PELVIC EXAM	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.49
X1370	FOL-UP W/O PEL EX INJECTI	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.4
X1380	REF-FOR STER/FOLL-UP W/O PELVIC	99211-99215	Office/outpatient visit, est.	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09
X1400	CONSEL VIS NONE DIS THIS VISI	99199	unlimited special service	FP	NEW OR ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.0 or V25.09
X1410	COUNSELING VISIT BIRTH C PILL	99199	unlimited special service	FP	NEW OR ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.01 OR V25.41

X1420	COUNSEL VISIT INTRAUTER DEUIC	99199	unlimited special service	FP	NEW OR ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V24.42
X1430	COUNSELING VISIT DIAPHRAGM	99199	unlimited special service	FP	NEW OR ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02 OR V25.4
X1440	FOAM WITH COUNSELING	99199	unlimited special service	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02 OR V25.4
X1470	COUNSELING VISIT INJECTIONS	99199	unlimited special service	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02 OR V25.4
X1480	REF FOR STERL WITH COUNSEL	99199	unlimited special service	FP	ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09
X1490	COUNSELING VISIT OTHER SPECIF	99199	unlimited special service	FP	NEW OR ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09 OR 25.49

X1495	COUNSELING PHYSICIAN 3 MO SUPPLY	99199	unlimited special service	FP	NEW OR ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS APPROPRIATE BASED ON SUPPLY
X1499	COUNSELING PHYSICIAN 6 MO SUPPLY	99199	unlimited special service	FP	NEW OR ESTABLISHED PATIENT CPT BILLED WITH FAMILY PLANNING DIAGNOSIS APPROPRIATE BASED ON SUPPLY
X1500	AN REV EX NONE DISPEN THIS VI	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.0 OR V25.09
X1510	ANN REV EXAM BIRTH CONTR PILL	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.01 OR V25.41
X1520	AN REV EX INTRAUTERINE DEVICE	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.1 OR V24.42
X1530	ANNUAL REV EXAM DIAPHRAM	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02 IR

					V25.4
X1540	ANNUAL REV EXAMINATION FOAM	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02 OR V25.4
X1560	ANNUAL REVISIT EXAM RHYTHM	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09 OR V25.49
X1570	ANNUAL REVISIT EXAM INJECTION	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.02 OR V25.4
X1580	REF FOR STER/ANNUAL REVIS/EXAM	S0612	Annual gynecological examination	FP	HCPC specific to annual billed with Family Planning Diagnosis V25.09 or V25.49
X1590	ANNUAL REVISIT EX OTHER SPECI	S0612	Annual gynecological examination	FP	HCPC SPECIFIC TO ANNUAL BILLED WITH FAMILY PLANNING DIAGNOSIS V25.09 OR V25.49
X4495	COUNSELING ARNP 3 MO SUPPLY	99199	unlimited special service	FP	
X4499	COUNSELING ARNP 6 MO SUPPLY	99199	unlimited special service	FP	

Y0226	TRIMMING OF NAILS (FOOT)	11719	Trim nails(s)		
Y1154	ARTHROPLASTY TOE ONE JOINT	28270	Release of foot contracture		

## 7.5 Dental Claim – ADA 2006 with NPI and Taxonomy

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

### ADA Dental Claim Form

HEADER INFORMATION																															
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination /Preauthorization <input type="checkbox"/> EPSDT/Title XIX																															
2. Predetermination /Preauthorization Number																															
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																															
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																															
PA# If applicable																															
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																															
3. Company/Plan Name, Address, City, State, Zip Code																															
13. Date of Birth (MM/DD/CCYY)																															
14. Gender <input type="checkbox"/> M <input type="checkbox"/> F																															
15. Policyholder/Subscriber ID (SSN or ID#) 1234567890																															
16. Plan/Group Number																															
17. Employer Name																															
OTHER COVERAGE																															
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																															
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																															
PATIENT INFORMATION																															
6. Date of Birth (MM/DD/CCYY)																															
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F																															
8. Policyholder/Subscriber ID (SSN or ID#)																															
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other																															
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																															
9. Plan/Group Number																															
10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																															
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Jane Doe (Member Name)																															
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																															
21. Date of Birth (MM/DD/CCYY)																															
22. Gender <input type="checkbox"/> M <input type="checkbox"/> F																															
23. Patient ID/Account # (Assigned by Dentist)																															
RECORD OF SERVICES PROVIDED																															
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description						31. Fee																			
1 01/07					D1110	Prophy						50.00																			
2																															
3																															
4																															
5																															
6																															
7																															
8																															
9																															
10																															
MISSING TEETH INFORMATION																															
34. (Place an "X" on each missing tooth)																															
Permanent																															
1	2	3	4	5	6	7	8	9	10	11	12	Primary						32. Other Fee(s)													
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	33. Total Fee
												50.00																			
35. Remarks																															
AUTHORIZATIONS																															
36. I have been informed of the treatment plan, and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X Patient/Guardian signature Date																															
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X Subscriber signature Date																															
ANCILLARY CLAIM/TREATMENT INFORMATION																															
38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input checked="" type="checkbox"/> Other																															
39. Number of Enclosures (00 to 99) Radiograph(s)    Oral Image(s)    Model(s)																															
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																															
41. Date Appliance Placed (MM/DD/CCYY)																															
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																															
43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																															
44. Date Prior Placement (MM/DD/CCYY)																															
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																															
46. Date of Accident (MM/DD/CCYY)																															
47. Auto Accident State																															
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																															
48. Name, Address, City, State, Zip Code Provider Name 1234 Any Street Any Town, KY 40600																															
49. NPI NPI of Clinic																															
50. License Number																															
51. SSN or TIN																															
52. Phone Number ( ) - -																															
52A. Additional Provider ID Taxonomy of Clinic																															
TREATING DENTIST AND TREATMENT LOCATION INFORMATION																															
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. Signature X Signed (Treating Dentist) Date																															
54. NPI rendering provider																															
55. License Number																															
56. Address, City, State, Zip Code Provider Name 1234 Any Street Any Town, KY 40600																															
56A. Provider Specialty Code Taxonomy rendering provider																															
57. Phone Number ( ) - -																															
58. Additional Provider ID																															

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To Reorder call 1-800-947-4746

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

**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>
	<p>Enter the tooth identification number or letter for the tooth treated (01-32 or A-T).</p> <p><b>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></p> <p><b>NOTE: Effective 6/1/05 use numeric quadrant codes and arch codes listed below.</b></p>

	<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 Subtotal 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 (\$).		
<b>35</b>	<b>Remarks</b>		
	Enter remarks when a procedure requires review that is gingivectomy, limited oral evaluation, exposure of an unerupted or impacted tooth for orthodontic reasons (that is soft tissue, partially bony or full bony).		

<b>38</b>	<b>Place of Treatment</b>	
	Enter the two digit code from the list below that identifies where the service was performed. Enter the two digit code in the box marked "other", even if the service was performed in the office.	
	Doctor's Office	11
	Patient's Home	12
	Mobile Unit	15
	Inpatient Hospital	21
	Outpatient Hospital	22
	Ambulatory Surgical Center	24
	Nursing Facility	32
	Day Care Facility (PSY)	52
	Night Care Facility (PSY)	52
	Other Locations	99
<b>40</b>	<b>Is Treatment for Orthodontics?</b>	
	If treatment is for orthodontic purposes (that is exposure of tooth, banding, etc.) mark yes.	
<b>45</b>	<b>Treatment Resulting from</b>	
	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).	
<b>46</b>	<b>Date of Accident</b>	
	If treatment is a direct result of an accident, enter the date of the 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 cannot be prior to the date of service. Stamped signatures are not accepted.
<b>54</b>	<b>NPI</b>
	Enter the Rendering 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 Taxonomy Number.
<b>57</b>	<b>Phone Number</b>
	Enter the provider's telephone number.

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## 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) or a CMS-1500 (02/12), which should be submitted to KY Medicaid according to Medicaid guidelines. To this claim, the provider must attach the corresponding Medicare Coding Sheet.

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

#### 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](http://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 the Medicare Coding Sheet may process accurately.

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

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

### 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

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

---

## 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

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

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

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

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## 10.2 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.

## 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.

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10 Appendix C

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

10 Appendix C

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 PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL	E OBS
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

## 10.4 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).

10 Appendix C

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

## 10.5 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).

10 Appendix C

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

## 10.6 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.

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10 Appendix C

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

**10.7 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.**

10 Appendix C

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 EOBS
				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.

## 10.8 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  
 PO BOX 5555  
 CITY, KY 55555-5555

PAYEE ID 99999999  
 NPI ID 99999999

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

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

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

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

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

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

REPORT: CRA-SUMM-R  
 RA#: 9999999

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

DATE: 02/01/2007  
 PAGE: 13

PROVIDER  
 P O BOX 555  
 CITY, KY 55555-0000

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

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

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

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

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

REPORT: CRA-EOBM-R COMMONWEALTH OF KENTUCKY (M1) DATE: 02/01/2007  
RA#: 9999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 14  
PROVIDER REMITTANCE ADVICE  
EOB CODE DESCRIPTIONS

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

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

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

**10.10 Summary Page**

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

**10.10.1 Payments**

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

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

**EXPLANATION OF BENEFITS**

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

**EXPLANATION OF REMARKS**

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

**EXPLANATION OF ADJUSTMENT CODE**

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

**EXPLANATION OF RTP CODES**

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

## 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	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		

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

## 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