Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions
For
Hospice Services
Provider Type – 44

Version 5.0

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Document Change Log

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1.1	01/19/2006	EDS	Updated Provider Rep list
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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

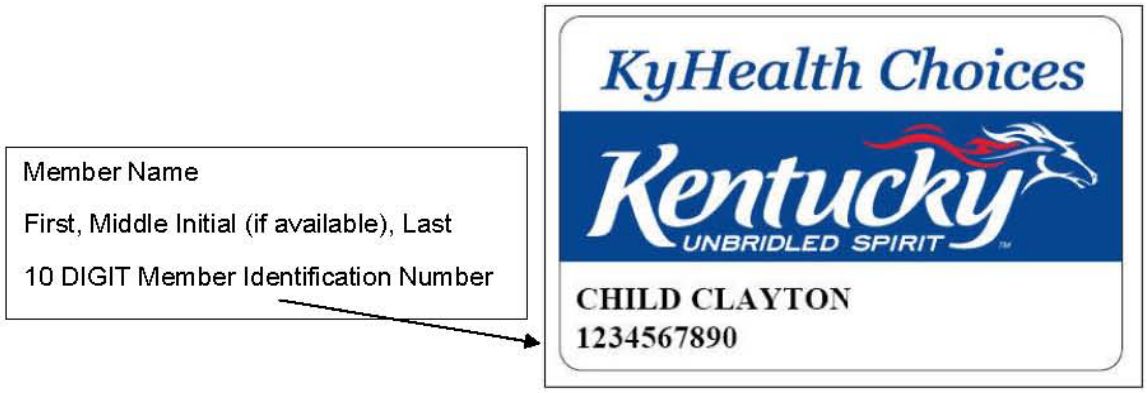
1.2 Member Eligibility

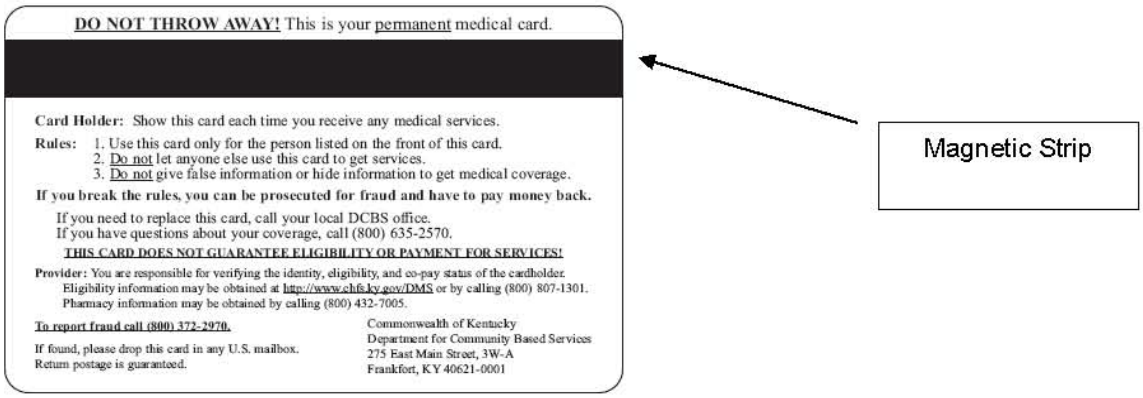
Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through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

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

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

1.2.1 Plastic Swipe KY Medicaid Card





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

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

1.2.2 Recipient 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 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 provide efficient tools for claim resolution, inquiries, and attendant claim related matters.

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

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

4.3 Optical Character Recognition

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

5 Additional Information and Forms

5.1 Claims with Dates of Service More than One Year Old

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

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

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

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

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

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

5.2 Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the 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.

Provider Inquiry Form

HP Enterprise Services Corporation

Post Office Box 2100

Frankfort, KY 40602-2100

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

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

. Provider's Message

10.

Signature Date

HP Enterprise Services Response: OFFICE USE ONLY

_____This claim has been resubmitted for possible payment.

_____This claim paid on _____in the amount of _____

_____This claim was denied on _____with EOB code_____

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

Other: _____

_____

Signature Date

_____

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

5.6 Prior Authorization Information

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

Access the kymmis website to obtain blank Prior Authorization forms.

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

Access to Electronic Prior Authorization request (EPA).

https://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.**

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

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

_____

_____

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

_____

_____

_____

13. Signature _____ 14. Date _____

DMS Approved: January 10, 2011

5.8 Cash Refund Documentation Form

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

HP Enterprise Services
P.O. Box 2108
Frankfort, KY 40602-2108
Attn: Financial Services

Please keep the following points in mind when refunding:

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

HP Enterprise Services

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

CASH REFUND DOCUMENTATION

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

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

Research for Refund: (Check appropriate blank)

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

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

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

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

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

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

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

Contact Name _____ **Phone** _____

DMS Approved: January 10, 2011

5.9 Return to Provider Letter

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

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

- Provider ID;
- Recipient Identification number;
- Recipient 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.
___ Missing ___ Not a valid provider number

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

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

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

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

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

07) ___ Medicare Coding Sheet does not match the claim
___Dates of Service _____Member Number _____Charges ____ Balance due in Block 30

08) __Other Reason-
_____
_____

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

Helpful Hints When Billing for Services Provided to a Medicaid Member

- The Member's Medicaid number on the CMS 1500 (08/05) must be entered Field 9A
- The Member's Medicaid number on the CMS 1500 (02/12) must be entered Field 1A
- The Member's Medicaid number on the UB04 must be entered 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

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

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

6 Completion of UB-04 Claim Form with NPI

The Uniform Billing form (UB-04) is used to bill Hospice services rendered to eligible KY Medicaid Program Recipients. In the case of electronic billing, the information should be in an 837 Institutional format.

A completed UB-04 paper copy is located on the next page.

UB-04 billing forms may be obtained from the address or telephone number listed below:

KY Hospital Association
P.O. Box 24163
Louisville, KY 40224
Telephone: 1-502-426-6220

IMPORTANT: The Recipient's KY Medical Recipient Identification Card should be carefully checked to see that the Recipient's name appears on the card. The card is valid for the period of time in which the medical services are to be rendered. Providers cannot be paid for services rendered to an ineligible person.

6.1 UB-04 Claim Form with NPI and Taxonomy

1 Provider Name
Street Address
City or Town ST ZIP
AC+Phone Number

3a PAT. CNTL # Patient Control Number
b. MED. REC. #
4 TYPE OF BILL 0813
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010107 THROUGH 013107
7

8 PATIENT NAME
9 PATIENT ADDRESS

10 BIRTHDATE 01021900
11 SEX
12 ADMISSION DATE 010107
13 HR 14 TYPE 15 SRC 16 DHR
17 STAT 30
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0155	Room & Board 01/01/07 - 01/31/07		010107	31	3120 00		
0001	PAGE ____ OF ____	CREATION DATE	013107	TOTALS	3120.00		

50 PAYER NAME: KyHealth Choices
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI Pay To NPI #
57 OTHER Pay ToTaxonomy#
PRV ID Facility zip code

58 INSURED'S NAME: JANE DOE
59 P REL
60 INSURED'S UNIQUE ID: 4000000000
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 518.81
67 G H P Q
68

69 ADMIT DX 518
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI NPI Number QUAL
LAST JONES FIRST JAMES
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI Nursing Facility NPI# QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS P/T 44 or MAP380
81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC National Uniform Billing Committee
UC9213257

6.2 Completion of UB-04 Claim Form with NPI and Taxonomy

6.2.1 Detailed Instructions

The following is a representative sample of codes and/or services that may be covered by KY Medicaid.

FIELD NUMBER	FIELD NAME AND DESCRIPTION	
1	**Provider Name, Address and Telephone**	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	**Patient Control Number**	
	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.	
4	**Type of Bill**	
	Enter the appropriate code to indicate the type of bill.	
	1st Digit	Enter Zero
	2nd Digit (Type of Facility)	8 = Hospice
	3rd Digit (Bill Classification)	1 = Hospice (Non Hospital Based) 2 = Hospice (Hospital Based)
	4th Digit (Frequency)	1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
6	**Statement Covers Period**	
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
	Do not include days prior to the date the Recipient's Hospice election period began.	
10	**Date of Birth**	
	Enter the Recipient's date of birth.	

12	**Admission Date**	
	Enter the date on which the Recipient was admitted to the Hospice program in numeric format (MMDDYY).	
17	**Patient Status Code**	
	Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the “through” date in Form Locator 6.	
	Status Codes Accepted by KY Medicaid	
	01	Discharged (left care of this hospice)
	30	Still a patient of this hospice
	40	Died at home
	41	Died at medical facility, such as hospital, SMF, ICF or Free Standing Hospice
	42	Place of death unknown
18 – 28	**Condition Codes**	
	Peer Review Organization (PRO) Indicator	
	Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee.	
	A1= Special Program Indicator for EPSDT	
31 – 34	**Occurrence Codes and Dates**	
	Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.	
	Accident Related Codes: 01 = Auto Accident 02 = No Fault Insurance Involved - Including Accident or Other 03 = Accident - Tort Liability 04 = Accident - Employment Related 05 = Other Accident - Not described by the other codes	
42	**Revenue Codes**	
	Enter the three digit revenue code identifying specific services provided. A list of revenue codes covered by KY Medicaid is located in Appendix F of this manual.	

	NOTE: Total charge Revenue code 0001 must be the final entry in column 42, line 23. **Total charge amount must be shown in column 47, line 23.**
43	**Description**
	Enter a From and Through date (within this billing period) in numeric format (MMDDYY) for each revenue code shown in field 42. Enter service dates for one calendar month only on each line, except in the case of respite care. **NOTE: Complete no more than 10 lines per billing statement.**
45	**Creation Date**
	Enter the invoice date or invoice creation date.
46	**Unit**
	Enter the quantitative measure of services provided per revenue code. Units are measured in days for codes 653, 182, 183, 184, 185, 654, 651, 655, and 656. Units are measured in hours for code 652, and in number of prescription drugs for 250. Units for Medicare co-payment are measured in days for 658 and in number of prescriptions for 659.
47	**Total Charges**
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry “total charges.” **NOTE: Total claim charge must be shown in field 47, line 23.**
50	**Payer Identification**
	Enter the names of payer organizations from which the provider expects payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.*
	*KY Medicaid is payer of last resort.
54	**Prior Payments**
	Enter the amount the facility has received toward payment of the claim. Third party payment should be entered in this area.
56	**NPI**
	Enter the PAY TO NPI number.
57	**Taxonomy**
	Enter the PAY TO Taxonomy number.

57B	**Other**
	Enter the facilities zip code of the pay to provider.
58	**Insured's Name**
	Enter the Recipient's name in Form Locators 58 A, B, and C that relates to KY Medicaid the payer in Form Locators 50 A, B, and C. Enter the Recipient's name exactly as it appears on the Recipient Identification card in last name, first name, and middle initial format.
60	**Identification Number**
	Enter the Recipient Identification number in Form Locators 60 A, B, and C that relates to the Recipient's name in Form Locators 58 A, B, and C. Enter the 10 digit Recipient Identification number exactly as it appears on the Recipient Identification card.
67	**Principal Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes describing the principal diagnosis.
67A – Q	**Other Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
76	**Attending Physician ID**
	Enter the Attending Physician NPI number. **NOTE: The UPIN number of the Attending Physician can be used for a limited time only. Please watch future mailings from KY Medicaid for updates.**
76	**NPI**
	Enter the Attending Physician NPI number.
78	**Other**
	Enter the NPI number of the Nursing Facility.

6.3 UB-04 Claim Form with NPI Alone

NOTE: KY Medicaid advises providers to use this method when a single NPI corresponds to a single KY Medicaid provider ID.

1 Provider Name
Street Address
City or Town ST ZIP
AC+Phone Number

3a PAT. CNTL # Patient Control Number
b. MED. REC. #
4 TYPE OF BILL 0813
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010107 THROUGH 013107

8 PATIENT NAME
9 PATIENT ADDRESS

10 BIRTHDATE 01021900
11 SEX
12 ADMISSION DATE 010107
13 HR 14 TYPE 15 SRC 16 DHR
17 STAT 30
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0155	Room & Board 01/01/07 - 01/31/07		010107	31	3120 00		
0001	PAGE ____ OF ____	CREATION DATE	013107	TOTALS	3120.00		

50 PAYER NAME: KyHealth Choices
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI Pay To NPI #
57 OTHER PRV ID

58 INSURED'S NAME: JANE DOE
59 P REL
60 INSURED'S UNIQUE ID: 4000000000
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 518.81
67 G H I J K L M N O P Q
68

69 ADMIT DX 518
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI NPI Number QUAL LAST JONES FIRST JAMES
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI Nursing Facility NPI# QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS P/T 44 or MAP380
81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC UC9213257

6.4 Completion of UB-04 Claim Form with NPI Alone

6.4.1 Detailed Instructions

The following is a representative sample of codes and/or services that may be covered by KY Medicaid.

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.

FIELD NUMBER	FIELD NAME AND DESCRIPTION	
1	**Provider Name, Address and Telephone**	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	**Patient Control Number**	
	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.	
4	**Type of Bill**	
	Enter the appropriate code to indicate the type of bill.	
	1st Digit	Enter Zero
	2nd Digit (Type of Facility)	8 = Hospice
	3rd Digit (Bill Classification)	1 = Hospice (Non Hospital Based) 2 = Hospice (Hospital Based)
	4th Digit (Frequency)	1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
6	**Statement Covers Period**	
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
	Do not include days prior to the date the Recipient's Hospice election period began.	

10	**Date of Birth**	
	Enter the Recipient's date of birth.	
12	**Admission Date**	
	Enter the date on which the Recipient was admitted to the Hospice program in numeric format (MMDDYY).	
17	**Patient Status Code**	
	Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the "through" date in Form Locator 6.	
	Status Codes Accepted by KY Medicaid	
	01	Discharged (left care of this hospice)
	30	Still a patient of this hospice
	40	Died at home
	41	Died at medical facility, such as hospital, SMF, ICF or Free Standing Hospice
	42	Place of death unknown
18 – 28	**Condition Codes**	
	Peer Review Organization (PRO) Indicator	
	Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee.	
	A1= Special Program Indicator for EPSDT	
31 – 34	**Occurrence Codes and Dates**	
	Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.	
	Accident Related Codes: 01 = Auto Accident 02 = No Fault Insurance Involved - Including Accident or Other 03 = Accident - Tort Liability 04 = Accident - Employment Related 05 = Other Accident - Not described by the other codes	

42	**Revenue Codes**
	Enter the three digit revenue code identifying specific services provided. A list of revenue codes covered by KY Medicaid is located in Appendix F of this manual.
	NOTE: Total charge Revenue code 0001 must be the final entry in column 42, line 23. **Total charge amount must be shown in column 47, line 23.**
43	**Description**
	Enter a From and Through date (within this billing period) in numeric format (MMDDYY) for each revenue code shown in field 42. Enter service dates for one calendar month only on each line, except in the case of respite care. **NOTE: Complete no more than 10 lines per billing statement.**
45	**Creation Date**
	Enter the invoice date or invoice creation date.
46	**Unit**
	Enter the quantitative measure of services provided per revenue code. Units are measured in days for codes 653, 182, 183, 184, 185, 654, 651, 655, and 656. Units are measured in hours for code 652, and in number of prescription drugs for 250. Units for Medicare co-payment are measured in days for 658 and in number of prescriptions for 659.
47	**Total Charges**
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry “total charges.” **NOTE: Total claim charge must be shown in field 47, line 23.**
50	**Payer Identification**
	Enter the names of payer organizations from which the provider expects payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.*
	*KY Medicaid is payer of last resort.
54	**Prior Payments**
	Enter the amount the facility has received toward payment of the claim. Third party payment should be entered in this area.

56	**NPI**
	Enter the PAY TO NPI number. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**
58	**Insured's Name**
	Enter the Recipient's name in Form Locators 58 A, B, and C that relates to KY Medicaid the payer in Form Locators 50 A, B, and C. Enter the Recipient's name exactly as it appears on the Recipient Identification card in last name, first name, and middle initial format.
60	**Identification Number**
	Enter the Recipient Identification number in Form Locators 60 A, B, and C that relates to the Recipient's name in Form Locators 58 A, B, and C. Enter the 10 digit Recipient Identification number exactly as it appears on the Recipient Identification card.
67	**Principal Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes describing the principal diagnosis.
67A – Q	**Other Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
76	**Attending Physician ID**
	Enter the Attending Physician NPI number. **NOTE: The UPIN number of the Attending Physician can be used for a limited time only. Please watch future mailings from KY Medicaid for updates.**
76	**NPI**
	Enter the Attending Physician NPI number.
78	**Other**
	Enter the NPI number of the Nursing Facility.

7 Completion of MAP Forms

7.1 Submitting MAP Forms

All MAP forms should be submitted to:

Carewise Health, Inc.
9200 Shelbyville Road, Suite 100
Attn: Medicaid Hospice
Louisville, KY 40222

7.2 Completion of the Other Hospitalization Statement (MAP-383)

If a hospice recipient is hospitalized for any condition not related to the terminal illness, an Other Hospitalization Statement (MAP-383) must be completed. The name of the hospital to which the recipient is being admitted, the name and Recipient Identification number of the recipient and the actual date of the hospital admission must be entered in the appropriate spaces.

The Diagnosis and the ICD-9-CM code, or the ICD-10-CM code for this hospitalization must be entered. The ICD-9-CM or the ICD-10-CM codes for the recipient's terminal illness must also be entered. The appropriate block regarding previous hospitalizations must be checked and the dates and the ICD-9-CM or ICD-10-CM codes for previous admissions must be entered when applicable. The form must be signed and dated by the medical director of the hospice.

The form shall be sent to the Carewise Health, Inc. for review along with documentation which includes the terminal diagnosis, the recipient's present condition and verification that the reason for this hospitalization is in no way related to the terminal illness. After review by the KY Medicaid Program, the form will be returned to the hospice agency marked "Approved by the KY Medicaid Program" or "Denied by the KY Medicaid Program" and signed by a KY Medicaid representative.

If approved, one copy must be sent to the admitting hospital and one copy retained by the hospice agency. Hospice services may not be billed during periods of hospitalization. If denied, the hospice agency must bill for the service using the revenue code for General Inpatient Care.

An example of the Other Hospitalization Statement (MAP-383) is found on the following page.

MAP-383 (Rev. 10/91)

OTHER HOSPITALIZATION STATEMENT

This is to certify that hospitalization at

_____

Name of Facility

for _____ beginning on

Member Name/MAID Number

_____ is not related to the terminal illness of this patient.

Date of Admission

The reason for this admission is _____/_____

Diagnosis ICD 9 CM Code

This patient's terminal illness is _____/_____

Diagnosis ICD 9 CM Code

Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the KyHealth Choices Program.

Signed: _____

Medical Director

_____

Hospice Agency

_____

Date

Please attach documentation verifying that hospitalization is not related to terminal illness.

Is this the first time this patient has been hospitalized for a condition not related to the terminal illness? ☐ Yes ☐ No

If no, dates of previous admission _____

Diagnosis for previous admission _____

ICD 9 CM Code

☐ Approved by the Medicaid Program ☐ Denied by the Medicaid Program

_____

Medicaid Signature Date

7.3 Completion of Hospice Drug Form (MAP-384)

If a hospice recipient requires drugs which are not related to his/her terminal illness, a Hospice Drug Form (MAP-384) must be completed and submitted to Carewise Health, Inc. with the Election of Benefits Form (MAP-374). Instructions for completion of the form are listed below:

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	**Date Submitted**
	Enter the date submitted.
2	**Recipient Name**
	Enter the name of the recipient.
3	**SSN**
	Enter the Social Security Number exactly as it appears on the Social Security Identification card.
4	**Medical Assistance ID Number**
	Enter the Recipient Identification Number exactly as it appears on the Recipient Identification card.
5	**DOB**
	Enter the Recipients date of birth.
6	**Date Medicaid Hospice Coverage Began**
	Enter the date Medicaid Hospice coverage began.
7	**Terminal Diagnosis**
	Enter the terminal diagnosis for the recipient.
8	**ICD-9 CM**
	Enter the ICD-9 CM code.
9	**Medications Required Prior to Hospice Admission?**
	Mark Yes or No.
10	**List Diagnosis for Requested Medication NOT Related to Terminal Illness**
	Leave blank.
11	**Diagnosis**

	Enter the diagnosis for the requested medication(s) that is not related to the terminal illness.
12	**ICD-9 CM**
	Enter the ICD-9 CM code.
13	**Drug/Dose/Frequency**
	Enter the drug name, dose, and frequency of the requested medication.
14	**Start Date**
	Enter the start date of the medication.
15	**End Date**
	Enter the end date of the medication.
16	**NDC**
	Enter the National Drug Code (NDC) for the prescription drug.
17	**Units**
	Enter the number of units required.
18	**Price Per Unit**
	Enter the actual price per unit.
19	**Dispensing Fee**
	Enter the dispensing fee.
20	**Total Charge**
	Enter the total charge for this prescription.
21	**Maximum Allowable**
	Leave Blank.
22	**Admission Date**
	Enter the admission date to the hospital.
23	**Discharge Date**
	Enter the discharge date from the hospital.
24	**Name of Hospital**

	Enter the name of the hospital facility.
25	**Prescribing Physician**
	Enter the name of the physician prescribing these drugs.
26	**Medication**
	Enter the name of the medication.
27	**Provider Certification and Signature**
	The original provider's signature or the signature of the provider's authorized agent is required. A facsimile signature is not acceptable.
28	**Date**
	Enter the date on which this invoice was signed and submitted to KY Medicaid.
29	**Provider Name**
	Enter the name of the Hospice agency.
30	**Telephone #**
	Enter the telephone number of the Hospice agency.
31	**Fax #**
	Enter the fax number of the Hospice agency.
32	**Address**
	Enter the address of the Hospice agency.
33	**Medicaid Provider ID**
	Enter the eight digit KY Medicaid provider ID. The number may begin with a "71" or a "44".

Both copies of the MAP-384 must be attached to the Election of Benefits Form (MAP-374). Documentation must also be attached that verifies the need for the listed prescriptions/items is not related to the recipient's terminal illness.

One copy will be returned to the provider by Carewise Health, Inc. with the allowable maximum KY Medicaid payment entered in Block 12 for each prescription. If payment is not allowed, "NA" will be entered in Block 12.

Only one copy of the MAP-384 is submitted, unless the hospice benefit is revoked or unless there is a change in the prescriptions required. The initial MAP-384 should be submitted with the recipient's Election of Benefit Form (MAP-374).

If the hospice benefit is revoked and then reinstated, a new MAP-384 should be sent with the second or third certification period. If there is a change in the prescriptions required, a MAP-384 must be submitted. The hospice agency should retain a copy of the invoice.

The MAP-384 must also be used when requesting prior approval for additional payment for nutritional supplements required for the recipient. The form should be completed as for regular prescriptions with the name of the nutritional supplement entered in Block 7 and the NDC number entered in Block 8.

Documentation from the attending physician which verifies that the nutritional supplements are required for the recipient's total nutrition must be attached to the MAP-384.

An example of the MAP-384 is on the following page.

MAP-384
(Rev. 1/12)

HOSPICE NON-RELATED DRUG FORM

Date submitted:	**Recipient Name**:	**SSN**:
Member ID:	DOB:	**Date Medicaid Hospice Coverage Began**:
Terminal Diagnosis:		**ICD-9 CM**:
Did recipient require these medication(s) prior to Hospice admission and diagnosis of the terminal illness ☐Yes ☐No		
List the diagnosis for requested medication(s) which are NOT related to the terminal illness		
Diagnosis:		**ICD-9 CM**:

List the medication(s) NOT related to the terminal illness.

Drug/Dose/Frequency	Start Date	End Date	NDC#	Units	Price Per Unit	Dispensing Fee	Total Charge	Maximum Allowance

Medication(s) related to hospitalization which is NOT related to the terminal illness.

Admission Date	Discharge Date	Name of Hospital	Prescribing Physician	Medication

PROVIDER CERTIFICATION AND SIGNATURE

This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient. DOCUMENTATION INDICATING THAT THESE PRESCRIPTIONS ARE NOT RELATED TO THE PATIENTS TERMINIAL ILLNESS MUST BE ATTACHED.

Signature _____ Date _____

PROVIDER INFORMATION

Name:	**Telephone #:**	**Fax#**:
Address:	**Medicaid Provider #:**	

CLEAR FORM

7.4 Completion of Other Services Statement (MAP-397)

For those services which are usually covered under the hospice benefit but are being billed separately because they have been determined to be totally unrelated to the terminal illness of the recipient, an Other Services Statement (MAP-397) must be completed in order to obtain approval from KY Medicaid. Instructions for completion of the form are listed below:

FIELD NUMBER	FIELD DESCRIPTION
1	The name of the agency providing the service, the name and Recipient Identification number of the recipient and the date of service must be entered in the appropriate spaces.
2	The ICD-9-CM code for the diagnosis must be entered.
3	The ICD-9-CM code describing the patient's terminal illness must be entered.
4	Items of durable medical equipment being billed separately must be specifically identified.
5	A description of hospital outpatient services and the reason for the services must be entered.
6	The form must be signed and dated by the medical director of the hospice agency.
7	Documentation verifying that the services are totally unrelated to the terminal illness of the recipient must be attached to the form.
8	All copies of the form must be submitted to: Carewise Health, Inc. 9200 Shelbyville Road, Suite 100 Attn: Medicaid Hospice Louisville, KY 40222 Two copies of the form will be returned to the provider signed by a KY Medicaid representative indicating whether separate payment for the services has been approved or denied.
9	If approved, one copy of the form must be sent to the provider who will bill for the service. The other copy should be retained by the hospice agency.

An example of MAP-397 is on the following page.

MAP-397 (Rev. 6/91)

Other Services Statement

This is to certify that the service(s) checked below provided by

_____

Name of Agency

for _____ beginning on

Member Name/MAID Number

_____ is/are not related in any way to the terminal illness

Date

of this patient.

The reason for the service(s) is _____/_____

Diagnosis ICD 9 CM Code

The patient's terminal illness is _____/_____

Diagnosis ICD 9 CM Code

Charges for this/these service(s) should not be billed to the hospice agency but should be billed directly to the KyHealth Choices Program.

Signed: _____

Medical Director

_____

Hospice Agency

_____

Date

☐ Durable Medical Equipment (List) _____

_____

_____

☐ Hospital Outpatient Services (Please Describe Service/Reason) _____

_____

Please attach documentation indicating service(s) is/are not related to terminal illness.

Is this the first time this patient has required services not related to terminal illness?

☐ Yes ☐ No

If no, date(s) of previous service _____.

Previous diagnosis not related to terminal illness for which services were required

_____

ICD 9 CM Code

_____ Approved by the Medicaid Program _____ Denied by the Medicaid Program

_____

Medicaid Signature Date

8 Appendix A

8.1 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

9 Appendix B

9.1 Remittance Advice

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

9.1.1 Examples Of Pages In Remittance Advice

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

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

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

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

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

9.2 Title

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

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

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

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

9.3 Banner Page

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

REPORT: CRA-BANN-R
RA#: 9999999

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

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

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

Commonwealth of Kentucky

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

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

 --ICN--          ATTENDING PROV.     SERVICE DATES   DAYS   ADMIT    BILLED AMT    ALLOWED AMT    SPENDDOWN      TPL AMT     PAID AMT
 PAT.ACCT NUM.                        FROM     THRU           DATE                                  COPAY AMT

MEMBER NAME: JANE DOE                     MEMBER NO.: MBRID99999
ICN9999999999        NPI9999999          030806 031006  2   030806      6,307.35           0.00         0.00        0.00      3,488.25
PATACCT 99999999999                                                                                     0.00

HEADER EOBS:  9932 00A2

REV CD HCPCS/RATE SRV DATE LVL CARE    UNITS     BILLED AMT  ALLOWED AMT   DETAIL EOBS
 120              030806    DEF         2.00     1,700.00         0.00   2527 0062 0883 0018
 250              030806    DEF        48.00       653.90         0.00   9932 0018
 258              030806    DEF         7.00       275.30         0.00   9932 0018
 270              030806    DEF        67.00       386.15         0.00   9932 0018
 300              030806    DEF        12.00       292.00         0.00   9932 0018
 310              030806    DEF         3.00       177.00         0.00   9932 0018
 360              030806    DEF         1.00     2,148.00         0.00   9932 0018
 370              030806    DEF         1.00       299.00         0.00   9932 0018
 710              030806    DEF         1.00       376.00         0.00   9932 0018


MEMBER NAME: JANE DOE                     MEMBER NO.: 9999999999
 9999999999999   9999999999             030806 031006  2   030806      6,307.35           0.00         0.00        0.00      3,488.25
  99999999999                                                                                           0.00

HEADER EOBS:  9932 0018

REV CD HCPCS/RATE SRV DATE LVL CARE    UNITS     BILLED AMT  ALLOWED AMT   DETAIL EOBS

 120              030806    DEF         2.00     1,700.00         0.00   9932 0018 0275 0015
 250              030806    DEF        48.00       653.90         0.00   9932 0015 0883 00
 258              030806    DEF         7.00       275.30         0.00   9932 0018
 270              030806    DEF        67.00       386.15         0.00   9932 0018
 300              030806    DEF        12.00       292.00         0.00   9932 0018
 310              030806    DEF         3.00       177.00         0.00   9932 0018
 360              030806    DEF         1.00     2,148.00         0.00   9932 0018
 370              030806    DEF         1.00       299.00         0.00   9932 0018
 710              030806    DEF         1.00       376.00         0.00   9932 0018

                        TOTAL UB CLAIMS PAID:                   12,614.70           0.00         0.00        0.00      6,976.50
```

9.4 Paid Claims Page

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

```
REPORT:   CRA-IPDN-R                          COMMONWEALTH OF KENTUCKY (M1)                                  DATE:  01/25/2007
RA#:      9999999                           MEDICAID MANAGEMENT INFORMATION SYSTEM                           PAGE:          11
                                                  PROVIDER REMITTANCE ADVICE
                                                       UB CLAIMS DENIED

PROVIDER                                                                                                 PAYEE ID              99999999
5555 ANY STREET                                                                                          NPI ID                99999999
SUITE 555                                                                                                CHECK/EFT NUMBER     999999999
CITY, KY 55555-0000                                                                                      ISSUE DATE          01/26/2007

   --ICN--       ATTENDING PROV.       SERVICE DATES   DAYS   ADMIT         BILLED          TPL       SPENDDOWN
 PATIENT ACCT.   NUM.                  FROM     THRU          DATE          AMOUNT         AMOUNT      AMOUNT

MEMBER NAME: JANE DOE                          MEMBER NO.: MBRID99999
ICN9999999999    NPI9999999                 021706 022106     4   021706      10,212.66          0.00          0.00
PATACCT9999

HEADER EOBS:  2660 0092

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS     BILLED AMT  DETAIL EOBS
 174              021706    DEF        4.00     9,382.04  2527 0062
 250              021706    DEF        3.00        15.96  9953 0062 0883 001
 300              021706    DEF        5.00       355.28  9953 0018
 301              021706    DEF       11.00       361.54  9953 0018
 302              021706    DEF        3.00        81.42  9953 0018
 306              021706    DEF        1.00        16.42  9953 0018


MEMBER NAME: JANE DOE                          MEMBER NO.: 9999999999
 9999999999999   MCD 9999                 021706 022106     4   021706      10,802.46          0.00          0.00
  99999999

HEADER EOBS:  2198 0016

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS     BILLED AMT  DETAIL EOBS
 111              021706    DEF        3.00     1,805.40
 112              021706    DEF        1.00       601.80
 250              021706    DEF      232.00       608.33
 258              021706    DEF       27.00       122.17
 272              021706    DEF        1.00       206.78
 300              021706    DEF        6.00       374.96
 301              021706    DEF       29.00       909.72
 307              021706    DEF        2.00        50.45
 312              021706    DEF        3.00       582.99
 370              021706    DEF        1.00       663.54
 460              021706    DEF        1.00        15.06
 720              021706    DEF        3.00     4,549.14
 732              021706    DEF        1.00       312.12

                        TOTAL UB CLAIMS DENIED:                      21,015.12         200.00          0.00
```

9.5 Denied Claims Page

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

REPORT: CRA-IPSU-R COMMONWEALTH OF KENTUCKY (M1) DATE: 01/25/2007
RA#: 9999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 17
PROVIDER REMITTANCE ADVICE
UB CLAIMS IN PROCESS

PROVIDER
5555 ANY STREET
SUITE 555
CITY, KY 55555-0000

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

--ICN-- PATIENT ACCT. NUM.	ATTENDING PROV.	SERVICE DATES FROM	THRU	DAYS	ADMIT DATE	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JOHN DOE		MEMBER NO.: MBRID99999						
ICN9999999999	NPI9999999	062206	062406	2	062206	4,010.60	0.00	0.00
PATACCT9999								

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL EOBS
111		062206	DEF	2.00	1,203.60	
250		062206	DEF	42.00	587.84	
258		062206	DEF	22.00	455.82	
272		062206	DEF	1.00	9.01	
370		062206	DEF	1.00	774.12	
410		062206	DEF	6.00	387.76	
710		062206	DEF	1.00	592.45	

TOTAL UB CLAIMS IN PROCESS:	4010.60	0.00	0.00

9.6 Claims In Process Page

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

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

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

 --ICN--          REASON CODE
9999999999999       01



  CLAIMS RETURNED:  01
```

9.7 Returned Claim

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

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

```
REPORT:   CRA-HHAD-R                    COMMONWEALTH OF KENTUCKY (M1)                    DATE:  01/23/2007
   RA#:      9999999                 MEDICAID MANAGEMENT INFORMATION SYSTEM              PAGE:          33
                                          PROVIDER REMITTANCE ADVICE
                                             UB CLAIM ADJUSTMENTS

PROVIDER                                                                    PAYEE ID              99999999
55555 ANY STREET                                                            NPI ID
CITY, KY 55555-0000


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

MEMBER NAME: JOHN DOE                    MEMBER NO.: 9999999999
  9999999999999  MCD 9999             030106 033106     (3,886.47)        (0.00)        (0.00)       (0.00)      (0.00)    (3,592.90)
   99999999999999

  9999999999999  MCD 9999             030106 033106      3,886.47          0.00          0.00         0.00        0.00          0.00
   99999999999999

HEADER EOBS:  0053 00A1


REV CD HCPCS/RATE SRV DATE  MODIFIERS      UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
 651              030106                   31.00     3,886.47         0.00  0686 0119
                                                                NET OVERPAYMENT (AR)                                   3,592.90

TOTAL NO. OF ADJ:       1
    TOTAL UB ADJUSTMENT CLAIMS:                                   0.00                       0.00                     0.00
                                                                     0.00                       0.00                 -3,592.90
```

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

9.8 Adjusted Claims Page

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

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

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

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

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


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

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

                            NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

                            NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

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

   1106           011306           0.00           22.41           0.00           22.41   92

                    TOTAL BALANCE                                                  22.41
```

9.9 Financial Transaction Page

9.9.1 Non-Claim Specific Payouts To Providers

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

9.9.2 Non-Claim Specific Refunds From Providers

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

9.9.3 Accounts Receivable

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

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

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

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

REPORT: CRA-SUMM-R
RA#: 9999999

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

DATE: 02/01/2007
PAGE: 13

PROVIDER

P O BOX 555
CITY, KY 55555-0000

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

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

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

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

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

REPORT: CRA-EOBM-R
RA#: 9999999

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

DATE: 02/01/2007
PAGE: 14

PROVIDER

P O BOX 555
CITY, KY 55555-0000

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

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

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

9.10 Summary Page

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

9.10.1 Payments

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

OTHER FINANCIAL	
NET EARNINGS	The 1099 amount.

EXPLANATION OF BENEFITS

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

EXPLANATION OF REMARKS

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

EXPLANATION OF ADJUSTMENT CODE

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

EXPLANATION OF RTP CODES

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

10 Appendix C

10.1 Remittance Advice Location Codes (LOC CD)

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

A	Active
B	Hold Recoup - Payment Plan Under Consideration
C	Hold Recoup - Other
D	Other-Inactive-FFP-Not Reclaimed
E	Other – Inactive - FFP
F	Paid in Full
H	Payout on Hold
I	Involves Interest – Cannot Be Recouped
J	Hold Recoup Refund
K	Inactive-Charge off – FFP Not Reclaimed
P	Payout – Complete
Q	Payout – Set Up In Error
S	Active - Prov End Dated
T	Active Provider A/R Transfer
U	HP Enterprise Services On Hold
W	Hold Recoup - Further Review
X	Hold Recoup - Bankruptcy
Y	Hold Recoup - Appeal
Z	Hold Recoup - Resolution Hearing

11 Appendix D

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

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

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

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

12 Appendix E

12.1 Remittance Advice Status Code (ST CD)

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

A Active

B Hold Recoup - Payment Plan Under Consideration

C Hold Recoup - Other

D Other-Inactive-FFP-Not Reclaimed

E Other – Inactive - FFP

F Paid in Full

H Payout on Hold

I Involves Interest – Cannot Be Recouped

J Hold Recoup Refund

K Inactive-Charge off – FFP Not Reclaimed

P Payout – Complete

Q Payout – Set Up In Error

S Active - Prov End Dated

T Active Provider A/R Transfer

U HP Enterprise Services On Hold

W Hold Recoup - Further Review

X Hold Recoup - Bankruptcy

Y Hold Recoup - Appeal

Z Hold Recoup - Resolution Hearing

13 Appendix F

13.1 Hospice Revenue Codes

The following is a three character code indicating the Hospice revenue code:

Revenue Code	Description	Unit Value
651	Routine Home Care	1 Day
652	Continuous Home Care	1 Day
655	Inpatient Respite Care	1 Day
656	Short Term Inpatient Care	1 Day
155	Room and Board – SNF	1 Day
159	Room and Board – ICF/MR/DD	1 Day
183	Bed Reservation – SNF – Recipient Return to Home	1 Day
185	Bed Reservation – SNF – Recipient Hospitalization	1 Day
182	Bed Reservation – ICF/MR/DD – Recipient Return to Home	1 Day
189	Bed Reservation – ICF/MR/DD – Recipient Hospitalization	1 Day
250	Pharmacy and Nutritional Supplements	1 Prescription