



# **Commonwealth of Kentucky KY Medicaid**

## **Provider Billing Instructions For Physician's Services Provider Type – 64, 65**

Version 6.5  
December 16, 2014

## Document Change Log

Document Version	Date	Name	Comments
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5.1	01/25/2012	Brenda Orberson Ann Murray	Updated section 7.2.1, field G to read "Beginning with dates of services January 1, 2012, anesthesia services should be submitted in actual minutes spent providing anesthesia services as the number of units. (The number of minutes will be converted into units during claims processing (15 minutes = 1 unit).) Do NOT add anesthesia base units to the actual time you submit. The base units are already included in the reimbursement." DMS approved 01/25/2012, John Hoffman
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# 1 General

## 1.1 Introduction

These instructions are intended to assist persons filing claims for services provided to Kentucky Medicaid Members. Guidelines outlined pertain to the correct filing of claims and do not constitute a declaration of coverage or guarantee of payment.

Policy questions should be directed to the Department for Medicaid Services (DMS). Policies and regulations are outlined on the DMS website at:

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

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

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

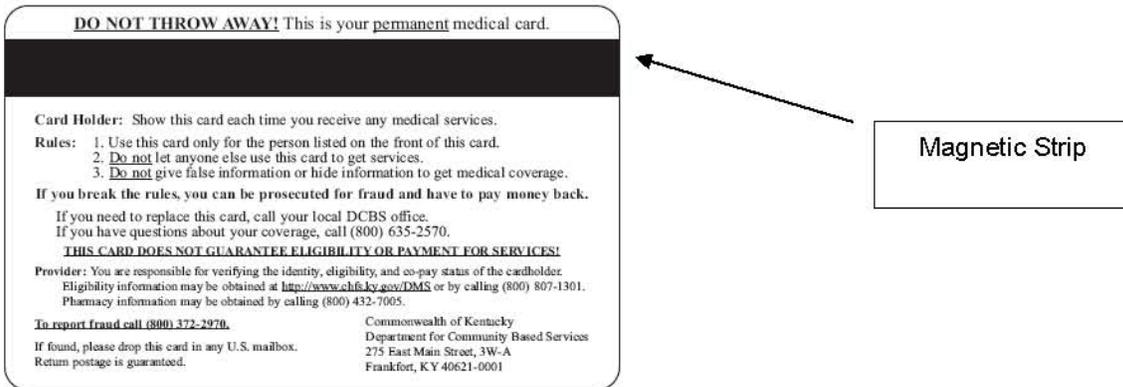
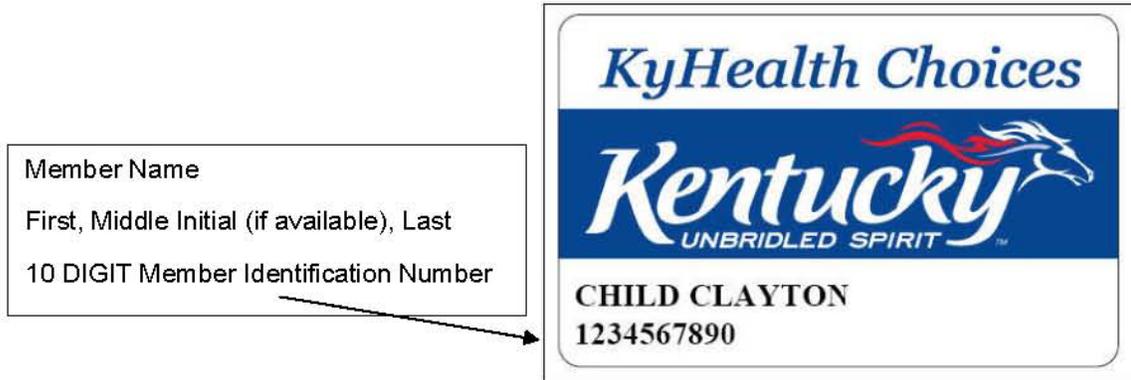
## 1.2 Member Eligibility

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

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

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

### 1.2.1 Plastic Swipe KY Medicaid Card



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

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

## 1.2.2 Member Eligibility Categories

### 1.2.2.1 QMB and SLMB

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

### 1.2.2.2 Managed Care Partnership

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

### 1.2.2.3 KCHIP

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

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

### 1.2.2.4 Presumptive Eligibility

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

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

- PE for pregnant women
- PE for hospitals

#### 1.2.2.4.1 PE for Pregnant Women

##### 1.2.2.4.1.1 Eligibility

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

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

Presumptive eligibility shall be granted to a woman if she:

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

#### **1.2.2.4.1.2 Covered Services**

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

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

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

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

##### **1.2.2.4.2.1 Eligibility**

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

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

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

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

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

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

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

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

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

This section covers:

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

### 1.2.3.1 Obtaining Eligibility and Benefit Information

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

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

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

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

The VREV system generally processes calls in the following sequence:

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

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

#### 1.2.3.1.2 KYHealth Net Online Member Verification

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

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## 5 Additional Information and Forms

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

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

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

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

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

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

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

### 5.2 Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the eligibility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KYHealth Net card issuance screen must be attached behind the paper claim.

### 5.3 Unacceptable Documentation

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received in a timely manner by HP Enterprise Services.

## 5.4 Third Party Coverage Information

### 5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.

### 5.4.2 Documentation That May Prevent a Claim from Being Denied for Other Coverage

The following forms of documentation prevent claims from being denied for other health insurance when attached to the claim.

1. Remittance statement from the insurance carrier that includes:
  - Member name;
  - Date(s) of service;
  - Billed information that matches the billed information on the claim submitted to Medicaid; and,
  - An indication of denial or that the billed amount was applied to the deductible.

**NOTE: Rejections from insurance carriers stating “additional information necessary to process claim” is not acceptable.**

2. Letter from the insurance carrier that includes:
  - Member name;
  - Date(s) of service(s);
  - Termination or effective date of coverage (if applicable);
  - Statement of benefits available (if applicable); and,
  - The letter must have 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

7

**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.kymmjs.com](http://www.kymmjs.com) or contact Billing Inquiry at 1-800-807-1232 for more information. You may also send an inquiry via e-mail at [ky\\_provider\\_inquiry@hp.com](mailto:ky_provider_inquiry@hp.com)

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

10.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**HP Enterprise Services Response: OFFICE USE ONLY**

\_\_\_\_\_ This claim has been resubmitted for possible payment.

\_\_\_\_\_ This claim paid on \_\_\_\_\_ in the amount of \_\_\_\_\_

\_\_\_\_\_ This claim was denied on \_\_\_\_\_ with EOB code \_\_\_\_\_

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

Other: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

## 5.6 Prior Authorization Information

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility 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.

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

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

DMS Approved: January 10, 2011

## 5.8 Cash Refund Documentation Form

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

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

Please keep the following points in mind when refunding:

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



## 5.9 Return to Provider Letter

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

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

- Provider ID;
- Member Identification number;
- Member first and last names; and,
- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;
- Claim lines completed exceed the limit; and,
- Unable to image.

HP

**RETURN TO PROVIDER LETTER**

Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dear Provider,  
The attached claim is being returned for the following reason(s). These items require correction before the claim can be processed.

- 01)  PROVIDER NUMBER – A valid 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

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

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

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## 6 Forms Requirements

The Health Insurance Claim Form CMS-1500 is used to bill for physician services provided to eligible KY Medicaid Program members. A CMS-1500 claim with information submitted in black typewritten form is recommended, although neat, printed, legible handwriting is acceptable. CMS-1500 claims can be obtained from:

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

The following MAP forms may be obtained on the HP Enterprise Services website:

[www.kymmis.com](http://www.kymmis.com)

Additional forms required for specific services include, but may not be limited to, the following:

- Drug Prior Authorization Form (MAP-82001, MAP-82101 and MAP 012802);
- Hysterectomy Consent Form (MAP-251);
- Sterilization Consent Form (MAP-250);
- Certification Form for Induced Abortion or Induced Miscarriage (MAP-235); and,
- Certification Form for Induced Premature Birth (MAP-236).

Required claims and forms completed incorrectly and submitted to KY Medicaid results in denial of payment. All forms should be completed according to KY Medicaid guidelines as outlined and detailed in these instructions. In certain situations involving the “automatic crossover” of claims, it may be necessary to follow the guidelines of two insurers concurrently (Medicare/Medicaid), as in this document, or to follow the guidelines designed for special billing situations, as related in this document. Example of Certification for Induced Abortion or Induced Miscarriage Form (MAP-235).

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---

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

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

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

\_\_\_\_\_ of \_\_\_\_\_  
(MAID #) (Patient's Address)  
(Please check appropriate box)

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

(Please indicate date and the procedure that was performed)

---

---

---

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Date

MAP-235 (2/00)

---

---

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

<b>Field</b>	<b>Description</b>
<b>Physician's Name</b>	Enter the physician's name.
<b>Patient's Name</b>	Enter the Member's name.
<b>Member Identification #</b>	Enter the Member's 10 digit Member Identification number.
<b>Patient's Address</b>	Enter the Member's address.
<b>(Please indicate date and the procedure that was performed.)</b>	Enter the date the procedure was performed and include any other pertinent information.
<b>Physician Signature</b>	The physician's actual signature is required. Stamped signatures are not acceptable.
<b>License Number</b>	Enter the physician's six digit Unique Physician Identification Number (UPIN) or other license number.
<b>Date</b>	Enter the date the form was signed by the physician.

---

---

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

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

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

\_\_\_\_\_ of \_\_\_\_\_  
(MAID #) (Patient's Address)  
(Please check appropriate box)

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

(Please indicate date and the procedure that was performed)

---

---

---

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Date

MAP-235 (2/00)

---

Example of Certification for Induced Premature Birth Form (MAP-236)

MAP-236 (8/78)

**CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH**

I, \_\_\_\_\_, certify that on the basis of  
(Physician's Name)  
my professional judgement, it was necessary to perform the following procedure on \_\_\_\_\_  
(Date)  
to induce premature birth intended to produce a live viable child. \_\_\_\_\_  
(Procedure)  
This Procedure was necessary for the health of \_\_\_\_\_  
(Name of Mother)  
\_\_\_\_\_ of \_\_\_\_\_  
(MAID #) (Address)  
and/or her unborn child.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Date

---

---

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

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

---

## 6.2 Diagnosis Coding

Physicians report member diagnoses on CMS-1500 claim forms using codes contained in the Internal Classification of Diseases Ninth Revision, Clinical Modification ICD-9-CM. KY Medicaid recognizes and accepts all codes from this reference, with the exclusion of the morphology of neoplasm codes, M800 through M997. The ICD-9-CM book of codes (order # OP-065-196) can be ordered from:

American Medical Association  
ATTN: Order Department  
P.O. Box 7046  
Dover, DE 19903-7046  
1-800-621-8335

## 6.3 Procedure Coding

Services and procedures performed for members by physicians are billed on the CMS-1500 claim form using levels 1 and 2 of the Centers for Medicare and Medicaid Services (CMS) Common Procedural Coding System (HCPCS).

Level 1 numeric five digit codes are those contained in the American Medical Association's Current Physicians' Procedural Terminology (CPT) book and should be entered on the CMS-1500 to report the majority of services and procedures performed by physicians. CPT books can be purchased from:

American Medical Association  
ATTN: Order Department  
P.O. Box 7046  
Dover, DE 19903-7046  
1-800-621-8335

**NOTE: The KY Medicaid Program provides reimbursement for covered services provided for Medicaid members according to the CPT/HCPCS codes (both levels) reported on the claim form and only as the descriptors of the codes in the CPT code book**

According to the information in the CPT code book, the American Medical Association (AMA) welcomes correspondence, inquiries and suggestions concerning CPT codes from physician members. Physician members may request assistance with coding for services that are universal or where there are no listed codes by written or telephone communication to:

Department for Coding and Nomenclature  
American Medical Association  
515 North State Street  
Chicago, IL 60610  
1-312-464-4737

---

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

The new CMS-1500 claim form is used to bill Medicaid physician services. A copy of a completed claim is shown on the following page.

Providers may order CMS-1500 claims from the:

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

HP Enterprise Services does not require an original CMS 1500 for processing.

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



## HEALTH INSURANCE CLAIM FORM

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

PICA												PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0000000000			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John						3. PATIENT'S BIRTH DATE MM DD YY 11 01 1950 M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) IF OTHER INSURANCE MAKES PAYMENT						10. IS PATIENT'S CONDITION RELATED TO: IF APPLICABLE		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER IF OTHER INSURANCE MAKES PAYMENT						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME IF OTHER INSURANCE MAKES PAYMENT						10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED DATE						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17b. NPI						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9													
A. 12345			B.			C.			D.				
E.			F.			G.			H.				
I.			J.			K.			L.				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
N412345678900 UN1 05 24 13 05 24 13		11	99213		EP	A	\$60 00		1	E	ZZ	XYZ9990000	
23. PRIOR AUTHORIZATION NUMBER IF APPLICABLE													
25. FEDERAL TAX I.D. NUMBER SSN EIN													
26. PATIENT'S ACCOUNT NO. 14 DIGITS				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ \$60 00		29. AMOUNT PAID \$ IF APPLICABLE		30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ralph Smidlap DATE 10/01/13				32. SERVICE FACILITY LOCATION INFORMATION If Applicable				33. BILLING PROVIDER INFO & PH # ( ) Your Place 100 Broadway Anytown, KY 40000					
a.				b.		a. "P ay to" NPI		b. ZZ Taxonomy					

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

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

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

### 7.2.1 Detailed Instructions

Claims are returned or rejected if required information is incorrect or omitted. Handwritten claims must be completed in black ink ONLY. Black typewriter ribbon must be used for typed claims.

The following fields are required and must be completed. The top, right, blank portion of the claim is reserved for HP Enterprise Services use only.

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	Check the "Medicare" and "Medicaid" blocks when billing a claim to <b>Medicare</b> to request Medicare to send the claim to Medicaid for processing coinsurance and deductible amounts.  Check the "Medicaid" block if the claim is to be processed by "Medicaid" <b>only</b> .
1A	<b>Insured's I.D. Number</b>
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
2	<b>Patient's Name</b>
	Enter the member's last name and first name exactly as it appears on the Member Identification card.
3	<b>Date of Birth</b>
	Enter the date of birth for the member.
9	<b>Other Insured's Name</b>
	Enter the Insured's Name. Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim.
9A	<b>Other Insured's Policy Group Number</b>
	Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. If this field is completed, also complete Fields 9D and 29.  NOTE: If other insurance denies the submitted claim, leave Fields 9, 9A, 9D and 29 blank and attach denial statement from other insurance carrier to the CMS-1500 (02/12) claim.

<b>9D</b>	<b>Insurance Plan or Program Name</b>
	Enter the Member's insurance carrier name. Complete only if entry in 9.
<b>10</b>	<b>Patient's Condition</b>
	Check the appropriate block if applicable.
<b>14</b>	<b>Date of Current</b>
	Enter the appropriate date, if you marked "Yes" in the fields 10A-10C.
<b>17B</b>	<b>Name of Referring Provider or Other Source</b>
	<b>Note: For Any claim prior to 11/01/2011, KenPAC or Lockin may be required.</b>
<b>19</b>	<b>Additional Claim Information</b>
	Enter the Physician Assistant's NPI Number, if applicable.
<b>21</b>	<b>Diagnosis or Nature of Illness or Injury</b>
	Enter a 9 in the ICD Indicator field in the upper right corner. Enter the required, appropriate ICD-9-CM diagnosis code. Twelve diagnosis codes may be entered.  <b>NOTE: Pathologists may use diagnosis code V72.6 for general, routine laboratory tests. Radiologists may use diagnosis code V72.5 for general, routine radiology services.</b>
<b>23</b>	<b>Prior Authorization Number</b>
	Enter the PA number assigned for these procedures.  <b>NOTE: See Physician fee schedule located at <a href="http://www.chfs.ky.gov/dms">www.chfs.ky.gov/dms</a> for procedure codes marked "R" indicating prior authorization required, or procedures listed on KYHealth Net.</b>
<b>24A</b>	<b>Date(s) of Service (Non-Shaded Area)</b>
	Enter the date or dates of service(s) in month, day, year numeric format (MMDDYY).  <b>NOTE: Span-dating is only allowed for identical services provided on consecutive dates of service. For providers who span-date, enter the corresponding number of consecutive days in Field 24G.</b>

<b>24A</b>	<b>NDC (Shaded Area)</b>	
	<p>Enter in the following order:  NDC qualifier (N4) 11-digit NDC code, one space, unit/basis of measurement qualifier (see list below), quantity</p> <p>The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (99999999.999). If entering a whole number, do not use a decimal. Do not use commas.</p> <p>F2= International Unit  ME= Milligram  UN= Unit  GR= Gram  ML= Milliliter</p>	
<b>24B</b>	<b>Place of Service</b>	
	<p>Enter the appropriate two digit place of service code which identifies the location where services were rendered. See Appendix C for a list of values.</p>	
<b>24D</b>	<b>Procedures, Services or Supplies CPT/ HCPCS (Non-Shaded Area)</b>	
	<p>Enter the appropriate HIPAA compliant procedure code identifying the service or supply provided for the member. Local codes are no longer valid for dates of service October 16, 2003 and after.</p> <p><b>NOTE: Effective July 1, 2007, providers are required to bill the actual NDC administered when billing a "J" HCPCS code on the CMS 1500. NDC is entered in 24A Shaded area. See instructions above.</b></p> <p>You may only bill one NDC per claim line detail.</p>	
	<b>Modifier (Non-Shaded Area)</b>	
	<p>Enter the appropriate HIPAA compliant two digit modifier, if applicable, that further describes the procedure code. Modifiers accepted by Medicaid are:</p>	
	24	Unrelated evaluation and management (E&M) service by the same physician during a postoperative period.
	25	Used only with an evaluation and management (E&M) service code and only when a significant, separately identifiable evaluation and management service is provided by the same provider to the same patient on the same day of the procedure or service. Documentation is not required to be submitted with the claim but appropriate documentation for the procedure and evaluation and management service must be maintained.
	26	Professional Component

	33	Preventive Services – effective dates of service 1/1/14
	50	Bilateral Procedure
	51	Multiple Procedures
	57	Decision for surgery. An evaluation and management (E&M) service that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E&M service.
	59	Distinct Procedural Service
	76	Repeat Procedure by Same MD
	77	Repeat Procedure by Another MD
	80	Assistant Surgeon
	TC	Technical Component
	GT	Telehealth Consultation
	Q6	Locum Tenens
	U1	Physician Assistant
	<b>Effective January 1, 2009, only Physicians who have a specialty of teleradiology may use the following modifiers:</b>	
	<b>Modifier</b>	<b>Description</b>
	U2	Teleradiology In-State
	U3	Teleradiology Out-of-State
	<b>LEVEL II HCPCS Modifiers</b> Only to be used with appropriate CPT codes.	
	<b>Modifier</b>	<b>Description</b>
	LT	Left side
	RT	Right side
	E1	Upper left, eyelid
	E2	Lower left, eyelid
	E3	Upper right, eyelid

	E4	Lower right, eyelid
	FA	Left hand, thumb
	F1	Left hand, second digit
	F2	Left hand, third digit
	F3	Left hand, fourth digit
	F4	Left hand, fifth digit
	F5	Right hand, thumb
	F6	Right hand, second digit
	F7	Right hand, third digit
	F8	Right hand, fourth digit
	F9	Right hand, fifth digit
	LC	Left circumflex, coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
	LD	Left anterior descending coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
	RC	Right coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
	TA	Left foot, great toe
	T1	Left foot, second digit
	T2	Left foot, third digit
	T3	Left foot, fourth digit
	T4	Left foot, fifth digit
	T5	Right foot, great toe
	T6	Right foot, second digit
	T7	Right foot, third digit
	T8	Right foot, fourth digit
	T9	Right foot, fifth digit

24D	Modifier (Shaded Area)	
	Enter the appropriate disposition code to define the EPSDT service or referral.  Enter the appropriate EPSDT referral code, if applicable, from appendix.	
	<b>Category</b> <b>R = Referred</b> <b>T = Treated</b>	<b>Disposition Code</b>
	Vision	VR, VT
	Hearing	HR, HT
	Dental	DR, DT
	Mental Health	MR, MT
	Lead	LR, LT
	Sickle Cell	SR, ST
	Family Planning/Pregnancy	FR, FT
	Growth, Endocrine, Nutrition	GR, GT
	Cardiac	CR, CT
	Orthopedic	OR, OT
	Genito-Urinary	UR, UT
	ENT/Respiratory	ER, ET
	Neurology	NR, NT
	Hemoglobin	BR, BT
	Other	TR, TT
	Immunizations	
	DPT	ID
	Polio	IP
	MMR	IM
	HIB	IB

	Other	IO
<b>24E</b>	<b>Diagnosis Code Indicator</b>	
	Enter the diagnosis pointers A-L to refer to a diagnosis code in field 21. Do not enter the actual diagnosis code.	
<b>24F</b>	<b>Charges (Non-Shaded Area)</b>	
	Enter the total usual and customary charge(s) for the service(s) provided for the member.	
<b>24G</b>	<b>Days or Units (Non-Shaded Area)</b>	
	Enter the number of times per line the procedure was performed for the member on this date.	
	<b>Anesthesia Billing</b>	
	Beginning with claims received January 1, 2012, anesthesia services should be submitted in actual minutes spent providing anesthesia services as the number of units. (The number of minutes will be converted into units during claims processing (15 minutes = 1 unit).) Do NOT add anesthesia base units to the actual time you submit. The base units are already included in the reimbursement.	
<b>24G</b>	<b>Documenting Time for Anesthesia Services (Shaded Area)</b>	
	For anesthesia services, enter the total number of minutes from the Anesthesia and Operative record based on the anesthesia start time and the anesthesia stop time.	
<b>24I</b>	<b>ID Qualifier (Shaded Area)</b>	
	Enter a ZZ to indicate Taxonomy.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>	
<b>24J</b>	<b>Rendering Provider ID # (Shaded Area)</b>	
	Enter the Rendering Provider's Taxonomy Number.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>	
	<b>(Non-Shaded Area)</b>	
	Enter the Rendering Provider's NPI Number.  <b>Note: If you are supervising a physician assistant, the supervising provider's NPI is listed in this field. The physician assistants NPI number is located in 19. If this is a physician assistant providing the service, remember to append the modifier U1 to</b>	

	the procedure code.
<b>26</b>	<b>Patient's Account No.</b>
	Enter the office account number you have assigned to this member, if desired. Up to 14 alpha/numeric characters are typed. The account number appears on the remittance statement you receive from KY Medicaid as the invoice number.
<b>28</b>	<b>Total Charge</b>
	Enter the total of all individual charges entered in column 24F. Total each claim separately.
<b>29</b>	<b>Amount Paid</b>
	Enter the amount paid, if any, by a private insurance. Do not enter a Medicare or Medicaid amount that may have been previously paid. Also, complete Fields 9, 9A and 9D.
<b>31</b>	<b>Date</b>
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
<b>32</b>	<b>Service Facility Location Information</b>
	If the address in Form Locator 33 is not the address where the service was rendered, Form Locator 32 must be completed.
<b>33</b>	<b>Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number</b>
	Enter the provider's name, address, zip code and phone number (including area code).
<b>33A</b>	<b>NPI</b>
	Enter the appropriate Pay to NPI Number.
<b>33B</b>	<b>(Shaded Area)</b>
	Enter ZZ and the Pay to Taxonomy Number.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>

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

- Be sure to include the “AS OF” date and “EOB” code when copying a remittance advice as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after six weeks from your submission date.
- Field 24B (Place of Service) requires a two digit code.
- Field 24E (Diagnosis Code Indicator) is a one digit only field.
- If any insurance other than Medicare/KY Medicaid makes a payment on services you are billing, complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- If insurance does not make a payment on services you are billing, attach the private insurance denial to the CMS-1500 claim form. Do not complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- An adjustment is a change made to a PAID claim or a PAID detail line of a claim.
- Do not submit an adjustment and refund for the same claim at the same time.
- Healthcare organizations have traditionally conducted business by trading information on preprinted paper forms. The variety and volume of paper-based exchanges has grown. This has forced healthcare organizations to seek more efficient ways of communicating. Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

### 7.4 Mailing Information

Send the completed claims to HP Enterprise Services for processing as soon as possible after the service is provided. Retain a copy in the office file.

Mail completed claims to:

HP Enterprise Services  
P.O. Box 2101  
Frankfort, KY 40602-2101

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## 7.5 Special Billing instructions

### 7.5.1 Assistant Surgeon Services

Assistant surgeon services may be billed by entering the appropriate CPT code corresponding to the primary surgical procedure and modifier 80 in field 24D of the claim form.

**NOTE: Assistant surgeon and primary surgeon services must be billed on separate claims. Physician Assistants may not bill with modifier 80.**

### 7.5.2 Multiple Medical/Surgical Procedures

Multiple medical or surgical procedures performed for a member during a single operative session must be listed separately on the same CMS-1500 claim by entering the corresponding CPT procedure codes in Field 24D. The submission of a physician claim for more than six Medical/Surgical procedures during one operative event necessitates the completion of more than one paper claim. With electronic claim format there is the ability to bill 50 details.

When additional procedures are billed on a second claim form with the same dates of service as the procedures billed on the first claim, the second claim automatically denies. To obtain payment for the additional procedures (those listed on the second or a third claim), the provider must:

- Submit another CMS-1500 listing the denied procedures;
- Attach the Remittance Advice showing denial of payment; and,
- Complete and mail to HP Enterprise Services an Adjustment and Claim Credit Request Form for the originally filed partial-paid claim for multiple medical/surgical procedures to the following address:

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

**NOTE: KY Medicaid does not make separate payment for procedures that are part of a more comprehensive service. Payment for the major procedure includes payment for any separately identified component parts of the procedure (that is, incidental or intrinsic procedures such as analysis of adhesions, appendectomy and so on).**

### 7.5.3 Newborn Care

Routine newborn care services may be reported by entering the mother's name and number on the claim form.

If using the CMS-1500 (02/12):

Enter the mother's name in Field 2 and the mother's Member Identification number in Field 1A.

The CPT code corresponding to the service must be entered in Field 24D.

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To report routine newborn care services provided after multiple birth events (that is, for twins, triplets, quadruplets and so on), enter the mother's name in Field 2 of the claim form and the mother's Member Identification number in Field 1A. The CPT code corresponding to the service provided must be entered in Field 24D with a notation "multiple birth" (that is, Twin A and Twin B) in the adjacent Unusual Circumstance field. Enter the number of units in Field 24G that corresponds to the number of times the procedure is performed (for example, on line one of the CMS form, 1 unit of service for one routine hospital visit on day one for Twin A. Line two of the CMS form, 1 unit of service for one routine visit on day one for Twin B).

Physician claims for routine newborn care services include:

- Initial normal newborn care (procedures 99460);
- Subsequent hospital normal newborn care (procedures 99462);
- Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn (procedure code 99464); and,
- Circumcision when performed during the time period the mother and newborn are hospitalized in the same hospital (procedures 54150, 54160).

**NOTE: Routine newborn care can be billed using the mother's Member Identification number and name only once per nine month period. When a newborn requires other than routine newborn care (for example, newborn resuscitation), the services must be billed under the baby's own name and Member Identification number.**

#### **7.5.4 Chemotherapy (Antineoplastic)**

Claims for chemotherapy and the administration thereof may be submitted for payment for members who have malignancy diagnoses. The malignancy diagnosis should be entered as the first diagnosis in Field 21 of the CMS-1500.

The administration of anti-neoplastic drugs may be reported on the CMS-1500 (02/12) claim by entering the appropriate CPT procedure code in Field 24D.

#### **7.5.5 VFC Vaccine Administration**

For dates of service prior to January 1, 2014, Medicaid did not reimburse vaccines provided by the Department for Health Services Vaccines for Children (VFC) program. Only the administration of vaccines was reimbursed for children under age 21 billed with the CPT code applicable to the vaccine used and a "26" modifier (in field 24D of the CMS claim).

As of dates of service January 1, 2014, vaccines will be paid by the following:

- For patients under age 19, bill KY Medicaid using the administration CPT and the vaccine CPT. If the vaccine was procured from the Vaccines for Children (VFC) program bill modifier SL with the vaccine CPT code. If not, bill the vaccine CPT without modifier SL.
- For patients 19 and older, bill KY Medicaid using the administration CPT and the vaccine CPT. Do not use modifier SL.

The 26 modifier is no longer used.

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## 8 Appendix A

### 8.1 Resubmission of Medicare/Medicaid Part B Claims

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

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

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

#### 8.1.1 Medicare Coding

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

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

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

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

- Black ink only. No colored ink, pencils or highlighters;
- No white out. Correction tape is allowed;
- If a service is paid in full by Medicare, those services do not need to be billed to Kentucky Medicaid. The allowed amount and paid amount from Medicare would be the same.
- When writing zeros do not put a line through the zero.
- When billing a claim with multiple detail lines, be sure that Medicare has allowed a payment on those services. If Medicare has denied a detail line, that detail must be on a separate claim with the Medicare EOMB attached.
- The documents must be listed in the following order:
  - Claim form;
  - Coding sheet;
  - NDC Detail Attachment, and;
  - Any other attachments that may be needed.



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### 8.1.3 Medicare Coding Sheet Instructions

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

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## 9 Appendix B

### 9.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by HP Enterprise Services to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

**11 – 10 – 032 - 123456**

**1      2      3      4**

1. Region

10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS
20	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
21	ELECTRONIC CLAIMS WITH ATTACHMENTS
22	INTERNET CLAIMS WITH NO ATTACHMENTS
40	CLAIMS CONVERTED FROM OLD MMIS
45	ADJUSTMENTS CONVERTED FROM OLD MMIS
50	ADJUSTMENTS - NON-CHECK RELATED
51	ADJUSTMENTS - CHECK RELATED
52	MASS ADJUSTMENTS - NON-CHECK RELATED
53	MASS ADJUSTMENTS - CHECK RELATED
54	MASS ADJUSTMENTS - VOID TRANSACTION
55	MASS ADJUSTMENTS - PROVIDER RATES
56	ADJUSTMENTS - VOID NON-CHECK RELATED
57	ADJUSTMENTS - VOID CHECK RELATED

2. Year of Receipt

3. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.

4. Batch Sequence Used Internally

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## 10 Appendix C

### 10.1 Place of Service Codes

The following is a two character place of service code indicating the location where services were rendered.

- 11 Office
- 12 Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room - Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance - Land
- 42 Ambulance - Air or Water
- 51 Inpatient Psychiatric Facility
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Treatment Center
- 56 Psychiatric Residential Treatment Center
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 99 Other Unlisted Facility

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## 11 Appendix D

### 11.1 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.

#### 11.1.1 Examples of Pages in Remittance Advice

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

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

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

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

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

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## 11.2 Title

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

REPORT: CRA-XBPD-R  
RA#: 9999999

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

DATE: 01/25/2007  
PAGE: 2

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

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

## 11.3 Banner Page

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

REPORT: CRA-BANN-R  
RA#: 9999999

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

DATE: 01/23/2007  
PAGE: 1

PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

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

Commonwealth of Kentucky

REPORT: CRA-BANN-R  
RA#: 9999999

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

DATE: 01/23/2007  
PAGE: 1

PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

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

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

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

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

## 11.4 Paid Claims Page

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

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

PROVIDER PAYEE ID 99999999  
 555 ANY STREET NPI ID  
 CITY, KY 55555-0000 CHECK/EFT NUMBER 000999999  
 ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES	BILLED	TPL	SPENDDOWN
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: 999999999		
2007017999999	060606 060606	200.00	0.00	0.00
9999999XXX				

HEADER EOB: 3015 0011

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

## 11.5 Denied Claims Page

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

REPORT: CRA-BANN-R  
 RA#: 9999999

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

DATE: 01/23/2007  
 PAGE: 1

PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

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

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

TOTAL CMS 1500 CLAIMS IN PROCESS: 200.00 0.00

### 11.6 Claims in Process Page

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

REPORT: CRA-IPPD-R  
RA#: 9999999

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

DATE: 01/30/2007  
PAGE: 2

PROVIDER  
5555 ANY STREET  
CITY, KY 55555-5555

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

--ICN-- REASON CODE  
999999999999 01

CLAIMS RETURNED: 01

**11.7 Returned Claim**

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

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

REPORT: CRA-PRAD-R  
 RA#: 9999999

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

DATE: 12/14/2006  
 PAGE: 2

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

PAYEE ID 99999999  
 NPI ID

--ICN--	SERVICE DATES		BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID
--PATIENT NUMBER--	FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE			MEMBER NO.: 9999999999					
999999999999	031103	031103	(20.00)		(0.00)		(0.00)	
99999				(20.00)		(0.00)		(20.00)
999999999999	031103	031103	20.00		0.00		0.00	
99999				20.00		0.00		20.00
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES RENDERING		BILLED	ALLOWED	
99	WP101		1.00	FROM	THRU	AMOUNT	AMOUNT	DETAIL E OBS
				031103	031103	20.00	20.00	0102 0029
TOTAL NO. OF ADJ:			1					
TOTAL CMS 1500 ADJUSTMENT CLAIMS:			0.00		0.00		0.00	
				0.00		0.00		0.00

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).

If a cash refund is submitted, an adjustment **CANNOT** be filed.  
 If an adjustment is submitted, a cash refund **CANNOT** be filed.

## 11.8 Adjusted Claims Page

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

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

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

REPORT: CRA-TRAN-R  
 RA#: 9999999

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

DATE: 12/26/2006  
 PAGE: 2

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

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

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

## 11.9 Financial Transaction Page

### 11.9.1 Non-Claim Specific Payouts to Providers

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

### 11.9.2 Non-Claim Specific Refunds from Providers

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

### 11.9.3 Accounts Receivable

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

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

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

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

REPORT: CRA-SUMM-R  
 RA#: 9999999

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

DATE: 02/01/2007  
 PAGE: 13

PROVIDER  
 P O BOX 555  
 CITY, KY 55555-0000

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

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

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

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

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

REPORT: CRA-EOBM-R  
 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.

**11.10 Summary Page**

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

**11.10.1 Payments**

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

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

**EXPLANATION OF BENEFITS**

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

**EXPLANATION OF REMARKS**

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

**EXPLANATION OF ADJUSTMENT CODE**

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

**EXPLANATION OF RTP CODES**

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

## 12 Appendix E

### 12.1 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

## 13 Appendix F

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

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

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

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

---

## 14 Appendix G

### 14.1 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