Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions for Supports for Community Living Provider Type – 33

Version 5.2

July 17, 2020

Document Change Log

Document Version	Date	Name	Comments
1.0	04/19/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.1	04/26/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.2	06/14/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.3	08/18/2006	Ann Murray	Updated with revisions requested by Stayce Towles.
1.4	08/28/2006	Ann Murray	Updated with revisions requested by Stayce Towles.
1.5	08/31/2006	Ann Murray	Updated with revisions requested by Stayce Towles.
1.6	09/18/2006	Ann Murray	Replaced Provider Representative table. v1.3 – 1.6 are actually the same as revisions were made back-to-back and no publication would have been made
1.7	01/02/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
1.8	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
1.9	02/15/2007	Ann Murray	Updated Appendix B, KY Medicaid card and ICN.
2.0	02/21/2007	Ann Murray	Replaced Provider Rep table.
2.1	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v1.7 – 2.1 are actually the same as revisions were made back-to-back and no publication would have been made
2.2	05/01/2007	Ann Murray	Updated and added claim forms and descriptors.
2.3	01/31/2008	Ann Murray	Updated
2.4	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.
2.5	03/09/2009	Cathy Hill	Made changes from KY Health Choices to KY Medicaid per Stayce Towles

Document Version	Date	Name	Comments
2.6	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept. for Medicaid Services per Stayce Towles
2.7	03/30/2009	Ann Murray	Made global changes per DMS request. v2.5 – 2.7 are actually the same as revisions were made back-to-back and no publication would have been made
2.8	09/08/2009	Ann Murray	Replaced Provider Rep list.
2.9	10/21/2009	Ron Chandler	Replace all instances of "EDS" with "HP Enterprise Services".
3.0	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @hp.com. Removed the HIPAA section. v2.9 – 3.0 are actually the same as revisions were made back-to-back and no publication would have been made
3.1	03/09/2010	Ron Chandler	Insert new provider rep list.
3.2	06/01/2010	Ann Murray	Updated Field Locator 24A with "*Do not span date this field. Each line item must reflect a single date of service."
3.3	01/18/2011	Ann Murray	Updated global sections.
3.4	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
3.5	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
3.6	02/21/2012	Brenda Orberson Ann Murray	Updated due to typing error.
3.7	02/22/2012	Brenda Orberson Ann Murray	Global updates made to remove all references to KenPAC and Lockin. DMS Approved 03/09/2012, John Hoffman
3.8	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
3.9	05/21/2012	Stayce Towles Ann Murray	Updated sections 6.2.1 and 6.4 based upon HP recommendation with DMS approval from Sheila Davis. DMS Approved 06/04/2012, Karen Martin

Document Version	Date	Name	Comments
3.10	08/15/2012	Stayce Towles Patti George	Section 6- Changed Taxonomy Qualifier from PXC to ZZ in form locators 24I and 33B per CO18459. (Update of Provider Inquiry form approved by John Hoffman on 08/30/12)
3.11	01/24/2013	Vicky Hicks Patti George	Update section 1.2.2.2 to reflect former Passport Members having a choice of MCOs as of 1/1/2013. DMS Approved 02/27/2013, John Hoffman
3.12	06/03/2013	Vicky Hicks Patti George	Updates to NET PAYMENT and NET EARNINGS descriptions in Section 8.10.1 DMS Approved 07/09/2013, John Hoffman
3.13	08/12/2013	Stayce Towles Patti George	Update to section 5.10- Provider Rep listing.
4.0	12/5/2013	Vicky Hicks Stayce Towles	Update to section 6- add new CMS-1500 and instructions DMS approved 12/12/2013, John Hoffmann
4.1	1/17/14	Stayce Towles	Updates appendix for SCL2 procedure codes per Sheila Davis and James Kimble. Sheila Davis approved 1/23/14
4.2	03/28/2014	Stayce Towles	Updates to sections 1-5 per DMS and removed CMS 1500 (08/05). Approved 4/7/14 by Lee Guice.
4.3	03/05/2015	Stayce Towles	Add Michelle P Waiver codes in appendix and corrected procedure codes for PDS services for SCL2. DMS approved, Sheila Davis, 3/10/2015.
4.4	07/08/2015	Stayce Towles	Updated detailed instructions for field 21 – diagnosis indicator. Approved by John Hoffmann, OATS, 7/6/15.
4.5	07/16/2015	Stayce Towles	Updated place of service codes per CO 24859
4.6	06/24/2016	Vicky Hicks	Updated rep list.
4.7	02/10/2017	Vicky Hicks	Added “Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides.” Approved by Charles Douglass, DMS, 2/1/17

Document Version	Date	Name	Comments
			Added information for form locators 17 and 17B regarding Referring and Ordering Providers. Approved by Charles Douglass, DMS, 2/8/2017
4.8	05/17/2019	Vicky Hicks Mary Larson	Updated: 1) HP/HPE to DXC, hpe.com to dxc.com, 2) Provider Rep Table, 3) all forms, 4) DMS URLs in Introduction, 5) ICD-9/ICD-9-CM to ICD-10
4.9	02/04/2020	Vicky Hicks	Updated CPT code 96152 and added CPT code 96158 per CO31093.
5.0	03/30/2020	Vicky Hicks	Added Place of Service code 02 with effective date 3/6/2020 per CO31301.
5.1	04/06/2020	Vicky Hicks	Added U3 modifier to denote 'Overtime beyond 40 hours per week/same employee. Please refer to the COVID-19 Waiver Updates – Billing Instructions website for additional information'. Added Procedure Code S5170- Home Delivered Meals Changes added by CO31314. Billing Instruction update approved by Cheryl Hannah.
5.2	07/17/2020	Vicky Hicks Mary Larson	Updated Provider Representative List extensions.

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1 General

1.1 Introduction

Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides.

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:

https://chfs.ky.gov/agencies/dms/Pages/default.aspx

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

https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx

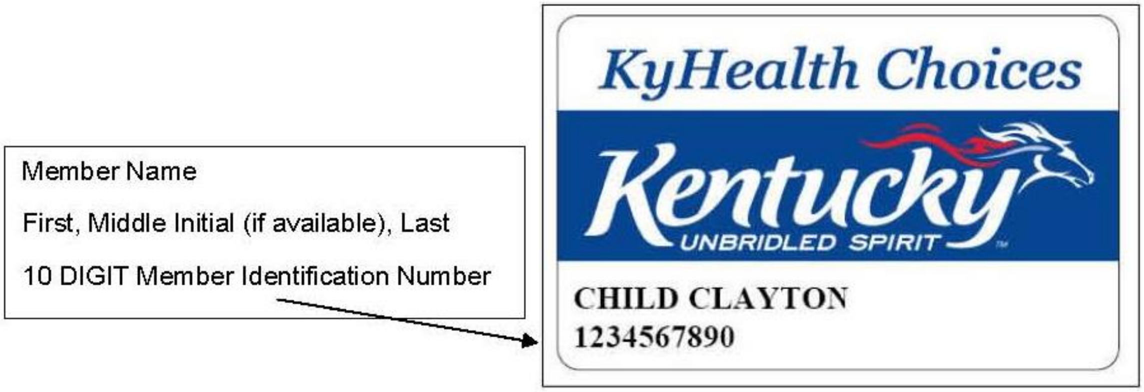
1.2 Member Eligibility

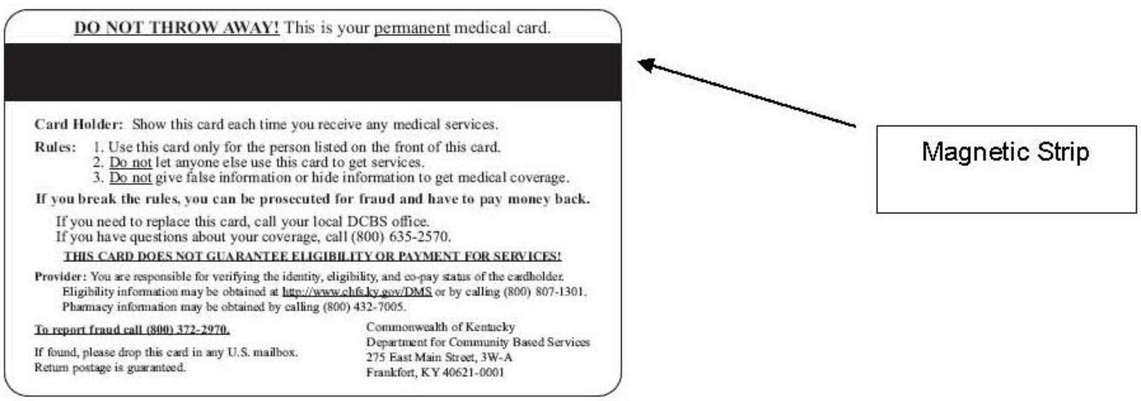
Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through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

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

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

1.2.1 Plastic Swipe KY Medicaid Card





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

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

1.2.2 Member Eligibility Categories

1.2.2.1 QMB and SLMB

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

1.2.2.2 Managed Care Partnership

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

1.2.2.3 KCHIP

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

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

1.2.2.4 Presumptive Eligibility

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

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

- PE for pregnant women
- PE for hospitals

1.2.2.4.1 PE for Pregnant Women

1.2.2.4.1.1 Eligibility

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

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

Presumptive eligibility shall be granted to a woman if she:

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

1.2.2.4.1.2 Covered Services

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

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

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

1.2.2.4.2 PE for Hospitals

1.2.2.4.2.1 Eligibility

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

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

1.2.2.4.2.2 Covered Services

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

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

   b. A pediatrician;
   c. An internist;
   d. An obstetrician or gynecologist;
   e. A physician assistant;
   f. A certified nurse midwife; or
   g. An advanced practice registered nurse;

2. Laboratory services;
3. Radiological services;
4. Dental services;
5. Emergency room services;
6. Emergency and nonemergency transportation;
7. Pharmacy services;
8. Services delivered by rural health clinics;
9. Services delivered by primary care centers, federally-qualified health centers and federally-qualified health center look-alikes;
10. Primary care services delivered by local health departments; or
11. Inpatient or outpatient hospital services provided by a hospital.

1.2.2.5 Breast & Cervical Cancer Treatment Program

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

1.2.3 Verification of Member Eligibility

This section covers:

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

1.2.3.1 Obtaining Eligibility and Benefit Information

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

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- KY HealthNet at https://home.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)

DXC Technology 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 KY HealthNet Online Member Verification

KY HealthNet online access can be obtained at https://home.kymmis.com. The KY HealthNet 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 DXC Technology Electronic Claims Department at KY_EDI_Helpdesk@dxc.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 DXC Technology Electronic Data Interchange Technical Support Help Desk at:

DXC Technology
P.O. Box 2100
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 DXC Technology 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 KY HealthNet

The KY HealthNet 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 KY HealthNet rather than paper claims submission. To become a KY HealthNet 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 KY HealthNet Companion Guides

Field-by-field instructions for KY HealthNet claims submission are available at:

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

4 General Billing Instructions for Paper Claim Forms

4.1 General Instructions

The Department for Medicaid Services is mandated by the Centers for Medicare and Medicaid Services (CMS) to use the appropriate form for the reimbursement of services. Claims may be submitted on paper or electronically.

4.2 Imaging

All paper claims are imaged, which means a digital photograph of the claim form is used during claims processing. This streamlines claims processing and provides efficient tools for claim resolution, inquiries, and attendant claim related matters.

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

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

4.3 Optical Character Recognition

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

5 Additional Information and Forms

5.1 Claims with Dates of Service More than One Year Old

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

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

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or DXC Technology 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 KY HealthNet verifying eligibility issuance date and eligibility dates must be attached behind the claim;
- A screen print from KY HealthNet 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 KY HealthNet 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 DXC Technology.

5.4 Third Party Coverage Information

5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

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

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

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

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

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

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

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

NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by DXC Technology 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 DXC Technology. DXC Technology 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 DXC Technology with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

DXC Technology
ATTN: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

5.4.4.1 TPL Lead Form

DXC Technology

DXC Technology
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:

DXC Technology
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 DXC Technology. A copy is returned with a response;
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;
- A toll free DXC Technology number **1-800-807-1232** is available in lieu of using this form; and,
- To check claim status, call the DXC Technology Voice Response on **1-800-807-1301** or you may use the KY HealthNet by logging into https://home.kymmis.com.

Provider Inquiry Form

DXC Technology
P.O. Box 2100
Frankfort, KY 40602

Please check claim status, verify eligibility, and download Remittance statements using KY HealthNet. Please contact the EDI Helpdesk at (800) 205-4696 for access information.

Provider Number	**Member Name**
Provider Name/Address	**Member ID Number**
Billed Amount	**Claim Service Date/(ICN if applicable)**

Providers Message

____

Signature/Date

DXC TECHNOLOGY RESPONSE:

	This claim was previously processed according to KY Medicaid guidelines. Claim will be sent for denial.
	This claim has been sent to processing.
	AGED CLAIM, claim will be sent for denial. See reverse side for timely filing guidelines.

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 for the specified individual only. This information is confidential. If you are not 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 KY HealthNet website to obtain blank Prior Authorization forms.

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

Access to Electronic Prior Authorization request (EPA).

https://home.kymmis.com

5.7 Adjustments and Claim Credit Requests

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

DXC Technology
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.

DXC Technology

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: DXC Technology
P.O. BOX 2108
FRANKFORT, KY 40602-2108
1-800-807-1232
ATTN: FINANCIAL SERVICES

NOTE: **A CLAIM CREDIT VOIDS THE CLAIM ICN FORM 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.**

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

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:

DXC Technology
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.

DXC Technology

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

CASH REFUND DOCUMENTATION

1 Check Number	**2. Check Amount**	
3. Provider Name/ID/Address	**4. Member Name**	
	5. Member Number	
6. From Date of Service	**7. To Date of Service**	**8. RA Date**
9. Internal Control Number (If server ICNs, attach RAs)		

Research for Refund: (Check appropriate blank)

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

________ **b.** **Billed in error**

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

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

________ **e.** **Paid to wrong provider**

________ **f.** **Money has been requested – date of the letter**
(attach a copy of letter requesting money)

________ **g.** **Other** ________________________________

Contact Name ________________________ **Phone** ________________________

DMS Approved: January 10, 2011

5.9 Return to Provider Letter

Claims and attached documentation received by DXC Technology 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.

DXC

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 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 DXC Technology at 1-800-205-4696 7:30 a.m. to 6 p.m. 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

Martha Edwards **502-209-3100** **Extension 3111045** **Martha.senn@dxc.com**			**Vicky Hicks** **502-209-3100** **Extension 3111016** **vicky.hicks@dxc.com**		
Assigned Counties			**Assigned Counties**		
ADAIR	GREEN	MCCREARY	ANDERSON	GARRARD	MENIFEE
ALLEN	HART	MCLEAN	BATH	GRANT	MERCER
BALLARD	HARLAN	METCALFE	BOONE	GRAYSON	MONTGOMERY
BARREN	HENDERSON	MONROE	BOURBON	GREENUP	MORGAN
BELL	HICKMAN	MUHLENBERG	BOYD	HANCOCK	NELSON
BOYLE	HOPKINS	OWSLEY	BRACKEN	HARDIN	NICHOLAS
BREATHITT	JACKSON	PERRY	BRECKINRIDGE	HARRISON	OHIO
CALDWELL	KNOX	PIKE	BULLITT	HENRY	OLDHAM
CALLOWAY	KNOTT	PULASKI	BUTLER	JEFFERSON	OWEN
CARLISLE	LARUE	ROCKCASTLE	CAMPBELL	JESSAMINE	PENDLETON
CASEY	LAUREL	RUSSELL	CARROLL	JOHNSON	POWELL
CHRISTIAN	LESLIE	SIMPSON	CARTER	KENTON	ROBERTSON
CLAY	LETCHER	TAYLOR	CLARK	LAWRENCE	ROWAN
CLINTON	LINCOLN	TODD	DAVIESS	LEE	SCOTT
CRITTENDEN	LIVINGSTON	TRIGG	ELLIOTT	LEWIS	SHELBY
CUMBERLAND	LOGAN	UNION	ESTILL	MADISON	SPENCER
EDMONSON	LYON	WARREN	FAYETTE	MAGOFFIN	TRIMBLE
FLOYD	MARION	WAYNE	FLEMING	MARTIN	WASHINGTON
FULTON	MARSHALL	WEBSTER	FRANKLIN	MASON	WOLFE
GRAVES	MCCRACKEN	WHITLEY	GALLATIN	MEADE	WOODFORD

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

6 Completion of CMS-1500 Paper Claim Form

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

Providers may order CMS-1500 claim forms from the:

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

Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides.

6.1 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 | CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0000000000

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1950 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): 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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES 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? YES 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

PATIENT AND INSURED INFORMATION

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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES 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.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											ZZ	XYZ9990000
	05 24 13	05 24 13	99		T2022	HI	A	$265 00	1		NPI	1234567890
2											NPI	
3										IF APPLICABLE	NPI	
4											NPI	
5											NPI	
6											NPI	

Of "Rendering Provider" for both ZZ and NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 14 DIGITS

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ $265 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

a. b.

33. BILLING PROVIDER INFO & PH # ( )

Your Place
100 Broadway
Anytown, KY 40000

a. "Pay to" NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

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

6.2.1 Detailed Instructions

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

The following fields must be completed:

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1A	**Insured's I.D. Number**
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
2	**Patient's Name**
	Enter the member's last name, first name and middle initial exactly as it appears on the Member Identification card.
3	**Date of Birth**
	Enter the date of birth for the member.
9	**Other Insured's Name**
	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	**Other Insured's Policy Group Number**
	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.
9D	**Insurance Plan or Program Name**
	Enter the Member's insurance carrier name. Complete only if entry in 9.
10	**Patient's Condition**
	Required if member's condition is related to employment, auto accident, or other accident. Check the appropriate block if member's condition relates to any of the above.

17	**Name of Referring Provider or Other Source**
	Enter the qualifier and the name of the Referring Provider or Ordering Provider, if applicable. **Qualifiers:** DN – Denotes Referring Provider DK – Denotes Ordering Provider
17B	**Name of Referring Provider or Other Source**
	Enter the Referring or Ordering Provider NPI, if applicable.
21	**Diagnosis or Nature of Illness or Injury**
	Enter an ICD indicator in the upper right corner to indicate the type of diagnosis being used. 9= ICD-9 0= ICD-10 Twelve diagnosis codes may be entered.
23	**Prior Authorization Number**
	Enter the appropriate Prior Authorization number, if applicable. **NOTE: See section 4.6 Prior Authorization for details.**
24A	**Date of Service (Non-Shaded Area)**
	Enter the date in month, day, year format (MMDDYY). *Do not span date this field. Each line item must reflect a single date of service.
24B	**Place of Service (Non-Shaded Area)**
	Enter the appropriate two digit place of service code which identifies the location where services were rendered. 02 – Telehealth (effective 3/6/2020) 12 – Home 99 – Other
24D	**Procedures, Services or Supplies CPT/ HCPCS (Non-Shaded Area)**
	Enter the appropriate HIPAA compliant HCPCS or CPT-4 procedure code identifying the service or supply provided to the member. **NOTE: See Appendix F for a list of the procedure codes.**

24D	**Modifier (Non-Shaded Area)**
	Enter the U3 modifier to denote Overtime beyond 40 hours per week/same employee. Please refer to the COVID-19 Waiver Updates – Billing Instructions website for additional information.
24E	**Diagnosis Code Indicator (Non-Shaded Area)**
	Enter the diagnosis pointers A-L to refer to a diagnosis code in field 21. Do not enter the actual ICD-10 diagnosis code.
24F	**Charges (Non-Shaded Area)**
	Enter the usual and customary charge for the service being provided to the member.
24G	**Days or Units (Non-Shaded Area)**
	Enter number of units of service provided for the member on this date of service.
24I	**ID Qualifier (Shaded Area)**
	Enter a ZZ to indicate Taxonomy. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**
24J	**Rendering Provider ID # (Shaded Area)**
	Enter Taxonomy Number. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**
	(Non-Shaded Area)
	Enter the appropriate NPI Number.
26	**Patient's Account No.**
	Enter the patient account number. DXC Technology types the first 14 or fewer digits. This number appears on the remittance statement as the invoice number.
28	**Total Charges**
	Enter the total of all individual charges entered in Field 24F. Total each claim separately.

29	**Amount Paid**
	Enter the amount paid, if any, by a private insurance carrier. Do not enter Medicare paid amount. Also, complete Fields 9, 9A and 9D. **NOTE: If other insurance denies the claim, leave these fields blank and attach the denial statement from the carrier to the submitted claim.**
31	**Date**
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
33	**Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number**
	Enter the provider's name, address, zip code and phone number.
33A	**NPI**
	Enter the appropriate Pay to NPI Number.
33B	**(Shaded Area)**
	Enter ZZ and the Pay To Taxonomy Number. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**

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

- Any required documentation for claims processing must be attached to each claim. Each claim is processed separately.
- Be sure to include the “AS OF” date and “EOB” code when copying a remittance advice as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after four weeks from your submission date.
- Field 24B (Place of Service) requires a two digit code.
- Field 24E (Diagnosis Code Indicator) is a one digit only field.
- When billing the same procedure code, for the same date of service, you must bill on one line indicating the appropriate units of service.
- If you are submitting a copy of a previously submitted claim on which some line items have paid and some denied, mark through or delete any line(s) on the claim already paid. If you mark through any lines, be sure to recompute your total charge in Field 28 to reflect the new total charge billed.

6.4 Mailing Information

Send the CMS-1500 claim form to DXC Technology for processing as soon as possible after the service is rendered. Retain a copy in the office file.

Mail completed claims to:

DXC Technology
P.O. Box 2101
Frankfort, KY 40602-2101

7 Appendix A

7.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by DXC Technology 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

8 Appendix B

8.1 Remittance Advice

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

8.1.1 Examples of Pages in Remittance Advice

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

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

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

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

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

8.2 Title

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

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

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

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

8.3 Banner Page

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

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

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

Commonwealth of Kentucky

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

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

--ICN-- / --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: 9999999999						
9999999999999	060606	060606	200.00		0.00			0.00
9999999XXX				18.05		0.00	2.00	16.05

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

	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
TOTAL CMS 1500 CLAIMS PAID:	200.00		0.00		0.00	
		18.05		0.00		16.05

8.4 Paid Claims Page

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

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

PROVIDER                                                                                  PAYEE ID          99999999
555 ANY STREET                                                                            NPI ID
CITY, KY 55555-0000                                                                       CHECK/EFT NUMBER  000999999
                                                                                          ISSUE DATE        01/26/2007
    --ICN--            SERVICE DATES          BILLED                TPL              SPENDDOWN
 --PATIENT NUMBER--    FROM     THRU          AMOUNT               AMOUNT              AMOUNT

MEMBER NAME: JANE DOE                 MEMBER NO.: 9999999999
  2007017999999        060606 060606          200.00                0.00                0.00
      9999999XXX

HEADER EOBS:   3015  0011

                                            SERVICE DATES    RENDERING                  BILLED
PL SERV      PROC CD     MODIFIERS     UNITS   FROM    THRU      PROVIDER                   AMOUNT       DETAIL EOBS
   22         88304         TC          1.00   060606 060606     MCD 64000000               200.00        0145  0011

               TOTAL  CMS 1500 CLAIMS DENIED:       200.00                0.00               0.00
```

8.5 Denied Claims Page

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

REPORT: CRA-BANN-R
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 999999999
ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES		BILLED	TPL
--PATIENT NUMBER--	FROM	THRU	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE	MEMBER NO.: 9999999999			
9999999999999	060606	060606	200.00	0.00
9999999XXX				

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

TOTAL CMS 1500 CLAIMS IN PROCESS: 200.00 0.00

8.6 Claims in Process Page

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

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

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

 --ICN--        REASON CODE
9999999999999      01



  CLAIMS RETURNED:  01
```

8.7 Returned Claim

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

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

REPORT: CRA-PRAD-R COMMONWEALTH OF KENTUCKY (M1) DATE: 12/14/2006
RA#: 9999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 2
PROVIDER REMITTANCE ADVICE
CMS CLAIM ADJUSTMENTS

HEALTH SERVICES PAYEE ID 99999999
ATTN: JANE DOE NPI ID
555 ANY STREET
CITY, KY 55555-0000

--ICN-- --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.:	9999999999					
9999999999999	031103	031103	(20.00)		(0.00)		(0.00)	
99999				(20.00)		(0.00)		(20.00)
9999999999999	031103	031103	20.00		0.00		0.00	
99999				20.00		0.00		20.00

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
99	WP101		1.00	031103	031103	MCD 40097065	20.00	20.00	0102 0029

TOTAL NO. OF ADJ: 1

	BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID
TOTAL CMS 1500 ADJUSTMENT CLAIMS:	0.00		0.00		0.00	
		0.00		0.00		0.00

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

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

8.8 Adjusted Claims Page

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

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

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

REPORT: CRA-TRAN-R | COMMONWEALTH OF KENTUCKY | DATE: 12/26/2006
RA#: 9999999 | MEDICAID MANAGEMENT INFORMATION SYSTEM | PAGE: 2

PROVIDER REMITTANCE ADVICE

FINANCIAL TRANSACTIONS

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

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

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

8.9 Financial Transaction Page

8.9.1 Non-Claim Specific Payouts to Providers

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

8.9.2 Non-Claim Specific Refunds from Providers

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

8.9.3 Accounts Receivable

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

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

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

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

REPORT: CRA-SUMM-R
RA#: 9999999

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

DATE: 02/01/2007
PAGE: 13

PROVIDER

P O BOX 555
CITY, KY 55555-0000

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

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

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

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

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

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

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

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

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

8.10 Summary Page

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

8.10.1 Payments

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

OTHER FINANCIAL	
NET EARNINGS	The 1099 amount.

EXPLANATION OF BENEFITS

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

EXPLANATION OF REMARKS

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

EXPLANATION OF ADJUSTMENT CODE

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

EXPLANATION OF RTP CODES

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

9 Appendix C

9.1 Remittance Advice Location Codes (LOC CD)

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

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

10 Appendix D

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

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

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

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

11 Appendix E

11.1 Remittance Advice Status Code (ST CD)

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

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

12 Appendix F

12.1 Supports for Community Living Waiver Codes (HCPCS)

The following is a five character code indicating the procedure:

Billing Codes	Description	Unit Value
T2016	Staffed Residence	1 Day
T1005	Respite	15 Minutes
T2022	Case Management	1 Month
H0039	Supported Employment	15 Minutes
H0004	Behavior Support/Intensive Outpatient	15 Minutes
H0002	Functional Analysis (Behavioral Health Screening)	15 Minutes
H0032	Behavioral Support Plan (Mental Health Service plan)	15 Minutes
90804	Psychological Service/Crisis Stabilization	15 Minutes
97530	Occupational Therapy	15 Minutes
92507	Speech Therapy	15 Minutes
97110	Physical Therapy	15 Minutes
S5126	Group Home	1 Day
H0043	Family Home	1 Day
97535	Community Living Supports	15 Minutes
E1399	Medical Items/Services	1 Item/Service
S5140	Adult Foster Care	1 Day
T2021 HB	Adult Day Training on-site	15 Minutes
H2021	Adult Day Training off-site	15 Minutes
T1028	Assessment/Reassessment	
T2021 HA	Children’s Day Habilitation	15 Minutes

12.1.1 SCL2 Codes Effective January 1, 2014

SCL2 Billing Codes for Services Provided by a Traditional Provider

	*Additional Modifier to Include if approved for **Exceptional Supports***			
Billing Codes	**Rate**	**Unit**	**Description**	**Unit Value**
T2022			Case Management	1 Month
97537	U1		Community Access Group	15 minutes
97535	U1		Community Access Individual	15 minutes
H2015			Community Guide (available if PDS services used)	15 minutes
T2038			Community Transition	Per Request
H0004 UA		U2	Consultative clinical and therapeutic (Diet/Nutrition)	15 minutes
H0004 HK		U2	Consultative clinical and therapeutic (Functional Analysis)	15 minutes
H0004 U7		U2	Consultative clinical and therapeutic (Positive Behavior Supports)	15 minutes
H0004 HE		U2	Consultative clinical and therapeutic (Psychological Services)	15 minutes
T2021	U1		Day Training	15 minutes
S5100			Day Training (Licensed Adult Day Health Center)	15 minutes
T2040			Financial Management (for PDS services)	15 minutes
97530			Occupational Therapy by OT	15 minutes

97139 GO			Occupational Therapy by OTA	15 minutes
H0023		U2	Person centered coach	15 minutes
T1019	U1	U2	Personal Assistance	15 minutes
97110			Physical Therapy by PT	15 minutes
97139 GP			Physical Therapy by PTA	15 minutes
96152			Positive Behavior Support Plan (end dated 12/31/2019)	Per Plan
96158			Health Behavior Intervention (this code replaced 96152 effective 1/1/2020)	Per Plan
T2016 UP	U1		Residential Level 1 - (3 or fewer residents)	1 day
T2016 US	U1		Residential Level 1 – (4 to 8 residents)	1 day
T2016	U1		Residential Level 2 – (12 or more hours)	1 day
S9976			Residential Level 2 – (Less than 12 hours)	1 day
T2031			Residential Tech Assisted	1 day
T1005	U1	U2	Respite	15 minutes
E1399			Special med equipment	Per Request
92507			Speech Therapy	15 minutes
T2019			Supported Employment (LONG TERM SUPPORT AND FOLLOW-UP)	15 minutes
T2019 U4			Supported Employment (PCJS DISCOVERY)	15 minutes
T2019 U5			Supported Employment (JOB DEVELOPMENT AND ANALYSIS)	15 minutes
T2019 U6			Supported Employment (JOB ACQUISITION WITH SUPPORT)	15 minutes
S5170			Home Delivered Meals	Per meal

***NOTE** Exceptional Supports requests must be reviewed and approved by DDID before being submitted for prior authorization. Requests are to be submitted via fax to (502) 564-2284 and must include the SCL Exceptional Supports Request Fax Form.

12.1.1.1 SCL2 Billing Codes for Services that are Participant Directed (PDS)

	Additional Modifier to Include if approved for ***Exceptional Supports****			
Billing Codes	**Rate**	**Unit**	**Description**	**Unit Value**
97537 HI	U1		Community Access Group (PDS)	15 minutes
97535 HI	U1		Community Access Individual (PDS)	15 minutes
H2015 HI			Community Guide (PDS)	15 minutes
T2021 HI	U1		Day Training (PDS)	15 minutes
T2028 HI			Environmental Accessibility Nonresidential (PDS)	Per Request
T1999 HI			Goods & Services (PDS)	Per Request
T2025 HI			Natural Support Training (PDS)	Per Training
T1019 HI	U1	U2	Personal Assistance (PDS)	15 minutes
T1005 HI	U1	U2	Respite (PDS)	15 minutes
T2032 HI			Shared Living (PDS)	Per Month
T2019 HI			Supported Employment (PDS) (LONG TERM SUPPORT AND FOLLOW-UP)	15 minutes
T2019 U4 HI			Supported Employment (PDS) (PCJS DISCOVERY)	15 minutes

T2019 U5 HI			Supported Employment (PDS) (JOB DEVELOPMENT AND ANALYSIS)	15 minutes
T2019 U6 HI			Supported Employment (PDS) (JOB ACQUISITION WITH SUPPORT)	15 minutes
T2003 HI			Transportation Nonresidential	Provided by: Individual - Per Mile Public Transport - Cost
T2039 HI			Vehicle Adaptation Nonresidential	Per Request
S5170			Home Delivered Meals	Per meal

***NOTE** Exceptional Supports requests must be reviewed and approved by DDID before being submitted for prior authorization. Requests are to be submitted via fax to (502) 564-2284 and must include the SCL Exceptional Supports Request Fax Form.

13 Appendix G

13.1 Billing Instructions for SCL Michelle P Waiver Services

Michelle P Waiver is a program that offers individuals with intellectual and developmental disability an alternative to institutional care. This waiver program allows individuals to remain in their homes with services and supports. In order to be a provider of MPW services you have to be a Supports for Community Living (SCL) provider. Services that can be provided by SCL providers under MPW are:

Service Code	Description
T2022	Case Management
S5130	Homemaker
T1019	Personal Care
T2021	Adult Day Training
H0039	Supported Employment
T1005	Respite
S5125	Attendant Care
E1399	Environmental & Minor Home Adaptations
H0004	Behavior Supports
97535	Community Living Supports
97530	Occupational Therapy (21 and over ONLY)
97110	Physical Therapy (21 and over ONLY)
92507	Speech (21 and over ONLY)
S5170	Home Delivered Meals