Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions for Hospital Services Provider Type – 01

Version 11.1

October 8, 2026

Document Change Log

Version	Date	Name	Comments
1.0	10/14/2005	HP Enterprise Services	Initial creation of DRAFT Home Health Services Provider Type – 34.
1.1	01/19/2006	HP Enterprise Services	Updated Provider Rep list.
1.2	02/16/2006	Carolyn Stearman	Updated with revisions requested by Commonwealth.
1.3	03/28/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.4	04/5/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.5	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.6	10/27/2006	Ron Chandler	Inserted new UB-04 claim form and descriptors.
1.7	11/14/2006	Lize Deane	Revisions made according to comment log.
1.8	11/15/2006	Lize Deane	Insert UB-04 with NPI.
1.9	01/03/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
2.0	01/29/2007	Ann Murray	Updated with revisions requested during walkthrough. v1.5 – 2.0 are actually the same as revisions were made back-to-back and no publication would have been made
2.1	02/15/2007	Ann Murray	Updated Appendix F, KY Medicaid card and ICN.
2.2	02/21/2007	Ann Murray	Updated FL4 in all detailed billing instructions and replaced Provider Rep table.
2.3	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v2.1 – 2.3 are actually the same as revisions were made back-to-back and no publication would have been made.
2.4	05/03/2007	Ann Murray	Updated and added claim forms and descriptors.
2.5	05/15/2007	John McCormick	Updated IAW Comment Log. v2.4 – 2.5 are actually the same as revisions were made back-to-back and no publication would have been made.
2.6	02/20/2008	Ann Murray	Updated form locators.

Version	Date	Name	Comments
2.7	05/19/2008	Cathy Hill	Made changes to provider list and presumptive eligibility per Stayce Towles.
2.8	05/20/2008	Cathy Hill	Made revisions requested by Stayce Towles. v2.7 – 2.8 are actually the same as revisions were made back-to-back and no publication would have been made.
2.9	07/08/2008	Ann Murray	Made revisions requested by Stayce Towles.
3.0	07/10/2008	Cathy Hill	Made revisions requested by Stayce Towles.
3.1	07/23/2008	Ann Murray	Updated with changes for Medicare. v2.9 – 3.0 are actually the same as revisions were made back-to-back and no publication would have been made.
3.2	11/17/2008	Cathy Hill	Made revisions requested by Stayce Towles.
3.3	02/19/2009	Cathy Hill	Inserted revised NDC form and directions as requested by Stayce Towles.
3.4	02/20/2009	Cathy Hill	Revised UB-04 forms and NDC attachment as requested by Stayce Towles.
3.5	03/09/2009	Cathy Hill	Made changes from KYHealth Choices to KY Medicaid per Stayce Towles.
3.6	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept for Medicaid Services per Stayce Towles.
3.7	03/19/2009	Cathy Hill	Added descriptions for Field 16, Discharge Hour, for the UB-04 form per Stayce Towles.
3.8	03/24/2009	Ron Chandler	Revised page 35, fields 43 and 44. Revised page 45, fields 43 and 44 per Stayce Towles.
3.9	3/30/2009	Ann Murray	Made global changes requested by DMS. v3.4 – 3.8 are actually the same as revisions were made back-to-back and no publication would have been made.
4.0	08/17/2009	Ann Murray	Removed MAP 235 and MAP 251 and updated the Form Requirement section.
4.1	9/8/2009	Ron Chandler	Inserted new Rep list per Stayce Towles. Removed Rev Code 981 from Appendix D and 981 Rev code statement from Appendix E.
4.2	10/20/2009	Ron Chandler	Replaced all instances of “EDS” with “HP Enterprise Services”.
4.3	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @HPE.com. Removed the HIPAA section.

Version	Date	Name	Comments
4.4	01/29/2010	Ron Chandler	Changed the date on the cover page to today's date per Stayce Towles.
4.5	3/8/2010	Ron Chandler	Inserted new provider rep list.
4.6	6/14/2010	Ron Chandler	Insert asterisk and comment in form locator 67 and 67 (A-Q) and table that comment refers to.
4.7	6/22/2010	Ron Chandler	Insert new UB04 forms per Patti George, revised tables in sections 5.2 and 5.4.
4.8	6/23/2010	Ron Chandler	Revise sections 5.2 and 5.4 form locator table. v4.5 – 4.6 are actually the same as revisions were made back-to-back and no publication would have been made.
4.9	8/6/2010	Ron Chandler	Revise sections 5.2, field 67, W. Added the word "admission."
5.0	9/27/2010	Patti George Ron Chandler	Deleted paper claim instructions for form locator 62 in both sections 5.2 & 5.4 per Patti George email.
5.1	11/16/2010	Patti George Ron Chandler	Revised per Patti George paper document with markup.
5.2	01/14/2011	Ann Murray	Updated global sections. v4.9 – 5.0 are actually the same as revisions were made back-to-back and no publication would have been made.
5.3	02/10/2011	Ann Murray	Added Revenue Code 948 to Appendix C and D per CO 15336.
5.4	05/04/2011	Patti George	Replace occurrences of SHPS with Carewise Health, Inc.
5.5	07/12/2011	Patti George	Add Discharge Status 21 per CO 13326.
5.6	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
5.7	12/20/2011	Stayce Towles Ann Murray	Added revenue code 615, 616 and 618 to Appendix B and C. DMS approved 01/04/2012, Alisha Clark.
5.8	02/08/2012	Stayce Towles Ann Murray	Updated the provider rep listing. DMS Approved 02/14/2012, John Hoffman.
5.9	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.

Version	Date	Name	Comments
6.0	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman,
6.1	05/16/2012	Stayce Towles Ann Murray	Deleted outpatient flat rate charges per Alisha Clark at DMS. DMS approved 05/24/2012, Alisha Clark.
6.2	06/04/2012	Stayce Towles Ann Murray	Updated sections 8 and added section 6.6 Duplicate or Inappropriate Payments based upon HPE recommendation with DMS approval from Alisha Clark. DMS approved, Alisha Clark 06/20/2012.
6.3	08/30/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012.
6.4	11/26/2012	Vicky Hicks Patti George	Add revenue code 483 - Echo cardiology to the Outpatient Revenue Code list per Alisha Clark. DMS approved by Alisha Clark, 12/11/2012.
6.5	01/16/2013	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 2/27/2013, John Hoffman.
6.6	06/04/2013	Vicky Hicks Patti George	Updates to NET PAYMENT and NET EARNINGS descriptions in Section 15.10.1. DMS Approved 07/09/2013, John Hoffman.
6.7	07/29/2013	Stayce Towles Patti George	Update section 5.10 - Provider Rep listing.
6.8	03/18/2014	Stayce Towles	Updated sections 1-5 per DMS. Approved 4-7-14 by Lee Guice.
6.9	05/07/2014	Stayce Towles	Per Harriett Devore DMS - Updated section 6.5.1 field 44 under CPT/rates corrected far as the first paragraph to say exactly the same thing as 6.3.1 field 44 that revenue codes 270-275 should be excluded. Approved 5/8/14, Harriett Devore.
7.0	07/30/2014	Stayce Towles	Updated requirements for revenue codes needing CPT's in FL 44. Approved, Charles Douglass 7/30/14.
7.1	08/08/2014	Stayce Towles	Added Revenue code 430 to outpatient services effective 7/4/14, per Charles Douglass.
7.2	01/30/2015	Stayce Towles	Added Revenue code 910 to outpatient services, effective 7/4/14, per Charles Douglass, DMS. Also, added GT modifier, form locator 66 and removed section 7.1.1 Outpatient Services

Version	Date	Name	Comments
			Provided. Approved 5/18/15, DMS, Charles Douglass.
7.3	11/09/2015	Donna Sims	Update verbiage on Form Locator 44 CPT/RATES to include revenue codes 300-314. Approved 11/4/2015, DMS, Charles Douglass.
7.4	2/9/2016	Vicky Hicks	Updated Rep List. Approved by Charles Douglass, DMS 2/9/16.
7.5	6/16/2016	Vicky Hicks	Updated Patient Status Codes. Approved by Charles Douglass DMS 6/29/2016.
7.6	11/10/2016	Vicky Hicks	Added verbiage "valid for crossover claims only" to Patient Status Code 61, Added Patient Status code 10 as valid. Approved by Charles Douglass, November 14, 2016.
7.7	02/01/2017	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 2/1/2017. Added form locators 78 and 80 regarding Referring and Attending provider information. Approved by Charles Douglass, DMS 2/8/2017.
7.8	12/01/2018	Vicky Hicks	Updated all references of HP or HPE to DXC Technology. Updated Representative list and Provider Inquiry form.
7.9	05/14/2019	Vicky Hicks Mary Larson	Updated: 1) Provider Rep Table, 2) all forms, 3) DMS URLs in Introduction, 4) ICD-9/ICD-9-CM to ICD-10.
8.0	04/24/2020	Vicky Hicks	Added Revenue Code 780 – Telemedicine per CO31359.
8.1	07/17/2020	Vicky Hicks Mary Larson	Updated Provider Representative List extensions.
8.2	10/08/2020	Vicky Hicks	Changed Form Locator 50 verbiage to clarify field requirement. Approved 10/8/2020 by Charles Douglass, DMS.
8.3	12/17/2020	Vicky Hicks Mary Larson	Updated Cash Refund Documentation Form. Form approved 03/06/2020 by John Hay, DMS. Updated *DXC Technology* to *Gainwell Technologies* or *Gainwell*, including all forms.

Version	Date	Name	Comments
			Added Revenue Code 771 for Outpatient Hospital services. Approved by Charles Douglass, DMS 12/2/20. Added Revenue Codes 430, 434, and 809 per CO31784.
8.4	01/04/2021	Vicky Hicks	Updated *DXC Technology* to *Gainwell Technologies* or *Gainwell* on Provider Inquiry form.
8.5	01/27/2021	Vicky Hicks Mary Larson	Edited the entire document for grammar, updated tables and reports, converted some lists to tables, added an acronym list as an Appendix.
8.6	02/03/2021	Vicky Hicks	Added revenue codes 914 (CO28630) and 915 (CO28497) to the inpatient and outpatient hospital revenue code lists and added 905 (CO29875) to the outpatient revenue code list. These codes were left off in error.
8.7	05/25/2021	Vicky Hicks	Per CO32374 and CO32492 respectively, Revenue Codes 260 and 771 must be billed with a Procedure Code. Per CO32641, replace Revenue Code 910 with Revenue Code 900.
8.8	10/27/2021	Vicky Hicks Mary Larson	Changed the logo on the title page and swipe card graphic per CO 33032. DMS approved 10/14/2021. Updated the Provider Representative List.
8.9	11/17/2021	Vicky Hicks	Updated M0239 code coverage per CO32132; M0243 per CO32247; Q0239 per CO32218. BI change approved by Jennifer Swingle, DMS, 11/17/2021
9.0	01/10/2022	Vicky Hicks	Further definition to timely filing added. Approved by Justin Dearinger, DMS, 01/07/2022.
9.1	01/12/2022	Vicky Hicks	Change Humana MCO name and phone number. Approved per John Hoffmann, 01/12/2022
9.2	08/22/2022	Vicky Hicks	Updated Revenue Code List per CO33876.
9.3	09/07/2022	Vicky Hicks	End date place of service code 10 per CO33980.
9.4	10/18/2022	Mary Larson	Updated logo on title page.

Version	Date	Name	Comments
9.5	02/16/2023	Vicky Hicks Mary Larson	Updated Medicare to include Medicare Part C and crossover text, where appropriate. Inserted a new Return to Provider letter. Reworded section 7.1 per Jennifer Swingle, DMS approved 2/16/2023.
9.6	03/13/2024	Vicky Hicks	Revisions to Section 6.3.1 Added H0038 remains a covered code but effective 1/1/2023 is billable with any revenue code other than 300 – 314, 360, 430, 450, 452, 456, 481, 682, 683, 684, and 900. Removed CPT list from 450 revenue code. Requested by Jennifer Swingle, DMS 03/11/2024
9.7	11/25/2024	Vicky Hicks	Added Section 9 Medicare Part B only. Approved by Jennifer Swingle, DMS, on November 25, 2024.
9.8	01/02/2025	Vicky Hicks Mary Larson	Updated the Provider Representative List, Contacts and Assigned Counties heading.
9.9	02/14/2025	Whitney Cole	Added prior authorization information to section 5.6 and section 8 per approval from Jennifer Swingle.
10.0	07/30/2025	Whitney Cole Mary Larson	Updated the Provider Representative List, Contacts and Assigned Counties heading.
10.1	08/11/2025	Whitney Cole	Under CO 36689 DMS has requested that the use of procedure code T2005 be end dated effective 05/31/2025. Effective with DOS 06/01/2025.
10.2	10/31/2025	Whitney Cole	Revisions to Section 6.3.1 Effective March 25, 2024: H0038 – Peer Support Services are allowed in a hospital outpatient setting only and can be billed with any revenue code except 360, 481, and 900.
10.3	11/13/2025	Whitney Cole	Revisions to update section 6.3.1, box 4 for interim billing.
10.4	12/02/2025	Whitney Cole	Adding claim submission verbiage for Cell and Gene Therapy (CGT) Access billing in section 7.2 special billing instructions.
10.5	12/09/2025	Whitney Cole	Updating verbiage to section 6.3.1, field locator 4, type of bill.

Version	Date	Name	Comments
10.6	01/20/2026	Whitney Cole	Updating verbiage to section 6.3.1, field locator 4, type of bill.
10.7	04/01/2026	Whtiney Cole	Adding section 7.2 helpful information on billing Incarcerated Members with Medicaid.
10.8	05/05/2026	Whitney Cole	Adding note on modifiers in section 6.3.1, field 44.
10.9	06/04/2026	Whitney Cole	Revisions to update section 6.3.1, field 43, to update information on National Drug Code (NDC), per DMS Jennifer Bohannon and Kelly Kitchen.
11.0	08/13/2026	Vicky Hicks Mary Larson	Global updates made to acceptable Timely Filing documentation. DMS Approved 08/13/2026, Kelly Kitchen. This document is ADA Compliant, 09/09/2026.
11.1	10/08/2026	Vicky Hicks Mary Larson	Addition to section 8 to clarify split billing of outpatient Medicare crossover claims. DMS Approved 10/08/2026, Jennifer Bohannon This document is ADA Compliant, 10/08/2026.

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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 (KY) 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

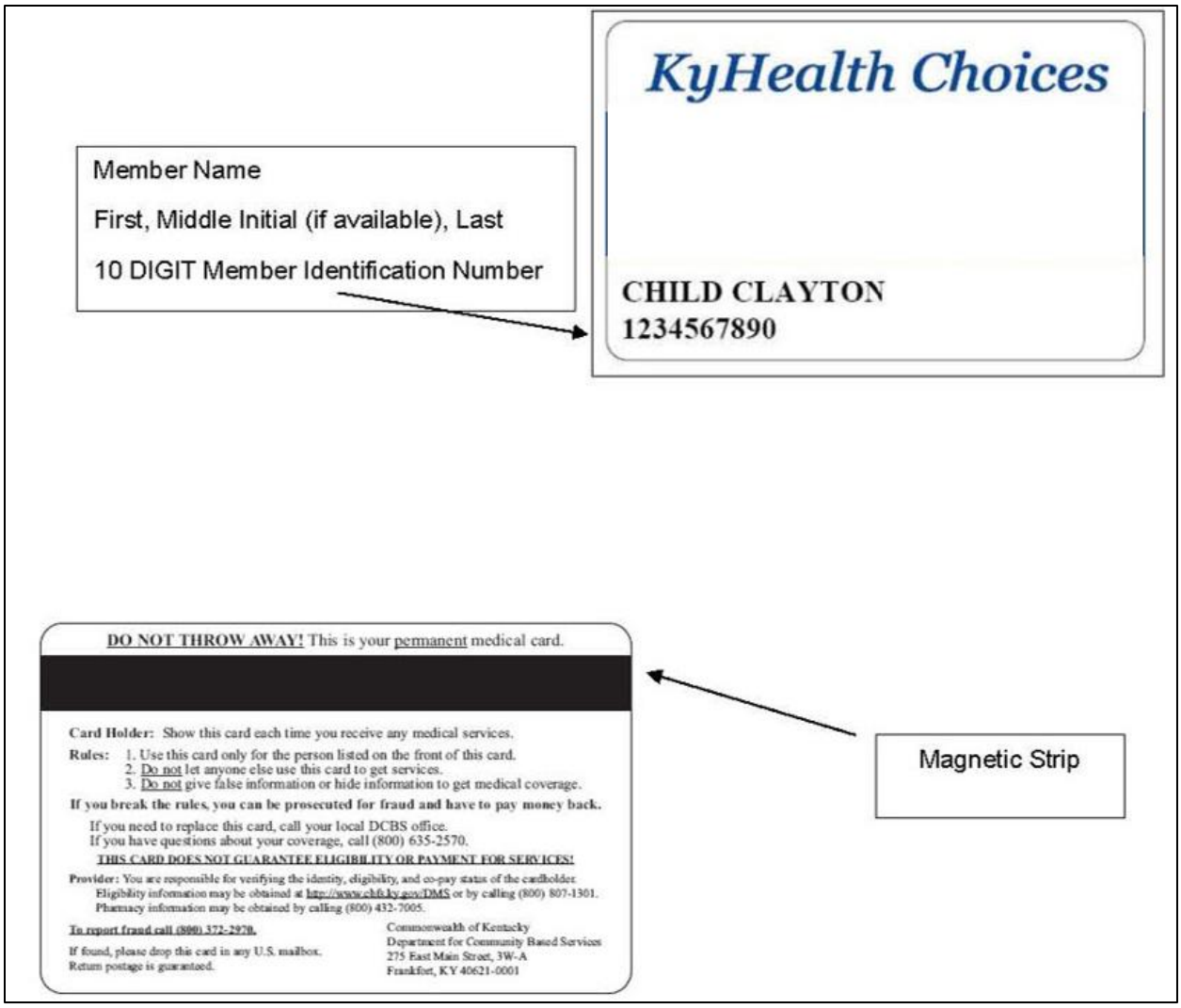
Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov) by phone at 1-855-4kynect (1-855-459-6328) or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through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

Figure 1: Plastic Swipe KY Medicaid Card



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 (now known as Molina) at 1-800-578-0775
- WellCare of Kentucky at 1-877-389-9457
- Humana Healthy Horizons in Kentucky at 1-800-444-9137
- Aetna Better Health of KY at 1-855-300-5528
- United Health Care at 1-866-633-4449

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:

- A family or general practitioner
- A pediatrician
- An internist
- An obstetrician or gynecologist
- A physician assistant
- A certified nurse midwife
- An advanced practice registered nurse
- A federally qualified health care center
- A primary care center
- A rural health clinic
- A local health department

Presumptive eligibility shall be granted to a woman if she:

- Is pregnant
- Is a Kentucky resident
- Does not have income exceeding 195 percent of the federal poverty level established annually by the United States Department of Health and Human Services
- Does not currently have a pending Medicaid application on file with the DCBS
- Is not currently enrolled in Medicaid
- Has not been previously granted presumptive eligibility for the current pregnancy

and

- 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:

- Services furnished by a primary care provider, including:
    - A family or general practitioner
    - A pediatrician
    - An internist
    - An obstetrician or gynecologist
    - A physician assistant
    - A certified nurse midwife
    - An advanced practice registered nurse

- Laboratory services
- Radiological services
- Dental services
- Emergency room services
- Emergency and nonemergency transportation
- Pharmacy services
- Services delivered by rural health clinics
- Services delivered by primary care centers, federally qualified health centers, and federally qualified health center look-alikes
- 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:

- Does not have income exceeding:
    - 138 percent of the federal poverty level established annually by the United States Department of Health and Human Services
    - 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
- Does not currently have a pending Medicaid application on file with the DCBS
- Is not currently enrolled in Medicaid

and

- Is not an inmate of a public institution

1.2.2.4.2.2 Covered Services

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

- Services furnished by a primary care provider, including:
    - A family or general practitioner
    - A pediatrician
    - An internist
    - An obstetrician or gynecologist
    - A physician assistant
    - A certified nurse midwife
    - An advanced practice registered nurse
- Laboratory services
- Radiological services

- Dental services
- Emergency room services
- Emergency and nonemergency transportation
- Pharmacy services
- Services delivered by rural health clinics
- Services delivered by primary care centers, federally qualified health centers and federally qualified health center look-alikes
- Primary care services delivered by local health departments
- 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
- 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

Gainwell Technologies 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 review, 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 Gainwell Electronic Claims Department at KY_EDI_Helpdesk@gainwelltechnologies.com or 1-800-205-4696.

All Member information is subject to Health Insurance Portability and Accountability Act (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

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 Gainwell Electronic Data Interchange Technical Support Help Desk at:

Gainwell Technologies
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 Gainwell 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 Electronic Claims Submission Help

Providers with questions regarding electronic claims submission (ECS) 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.

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

3.2 KY HealthNet Companion Guides

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

http://www.kymmis.com/kymmis/Provider Relations/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 the claim is not typed or computer generated
- Do not use white-out or shiny correction tape
- 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, Medicare Part C (Medicare Advantage), 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 Gainwell 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. Proof of timely filing documentation must show that the claim has been received and processed at least once every twelve month period from the service date.

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

- A screen print from KY HealthNet verifying the eligibility issuance date and eligibility dates must be attached behind the claim
- A screen print from KY HealthNet verifying filing within 12 months from the date of service, such as the appropriate section of the Remittance Advice (RA) 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 or Medicare Part C (Medicare Advantage) adjudication date
- A copy of the commercial insurance carrier’s Explanation of Benefits (EOB) received 12 months after service date but less than six months after the commercial insurance carrier’s adjudication date
- A copy of the MCO Paid remittance statement and a copy of the MCO Void remittance statement must be attached behind the claim when an MCO member's eligibility is retroactively changed to be a KY Medicaid member. Claim must be received and processed by KY Medicaid within one year of the MCO Void EOB 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 Gainwell.

5.4 Third Party Coverage Information

5.4.1 Commercial Insurance Coverage (this does NOT include Medicare or Medicare Part C (Medicare Advantage))

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:
   a. Member name
   b. Date(s) of service
   c. Billed information that matches the billed information on the claim submitted to Medicaid

   and

   d. 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:
   a. Member name
   b. Date(s) of service(s)
   c. Termination or effective date of coverage (if applicable)
   d. Statement of benefits available (if applicable)

   and

   e. The letter must have a signature of the 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:
   a. Member name
   b. Date(s) of service
   c. Name of insurance carrier
   d. Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached
   e. Termination or effective date of coverage

   and

f. 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:
   a. For the same member
   b. For the same or related service being billed on the claim

   and

   c. 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 Gainwell 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:
   a. Member name
   b. Date of insurance or employee termination or effective date (if applicable)

   and

   c. 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 Gainwell. Gainwell 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 Gainwell with an attached letter containing any relevant information, such as, names of attorneys, other involved parties, and/or the member's employer to:

Gainwell Technologies
ATTN: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

5.4.4.1 Third Party Liability Lead Form

Figure 2: Third Party Liability Lead Form

Gainwell Technologies

Gainwell Technologies
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 December 7, 2020

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:

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

Figure 3: Provider Inquiry Form

Provider Inquiry Form

Gainwell Technologies
P.O. Box 2100
Frankfort, KY 40602

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

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

Provider's Message:

_____

_____

_____ _____

Signature Date

Gainwell Technologies 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.
	Documentation attached is being returned due to no claim form attached to request.

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 contains 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

Please consider the following regarding Prior Authorization:

- 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
- Medicaid inpatient claims require prior authorization unless Medicare A or equivalent Medicare C policy Processes the claim.

Access the KYMMIS website to obtain blank Prior Authorization forms:

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

Access to an Electronic Prior Authorization (EPA) request:

https://home.kymmis.com

5.7 Adjustments and Void Requests

An adjustment is a change to be made to a “PAID” claim. The mailing address for the Adjustment and Void Request Form is:

Gainwell Technologies
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 or Medicare Part C (Medicare Advantage) crossover, attach an Explanation of Medicare Benefits (EOMB) 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
- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely

Figure 4: Adjustment and Void Request Form

Gainwell Technologies

ADJUSTMENT AND VOID REQUEST FORM

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

NOTE: A VOID IS TO BE USED TO REMOVE YOUR CLAIM FROM A "PAID" STATUS. A 'NEW' CLAIM CAN THEN BE SENT IF NECESSARY. AN ADJUSTMENT IS USED TO CHANGE INFORMATION ON A PAID CLAIM, SUCH AS UNITS, DOLLAR AMOUNTS, ETC. YOU MAY PERFORM ADJUSTMENTS OR VOIDS ELECTRONICALLY USING KYHEALTHNET IN MOST CASES.

<table>
<tr><td colspan="2">CHECK APPROPRIATE BOX:
☐ CLAIM ADJUSTMENT ☐ VOID</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 void request.

_____

_____

_____

13. Signature _____ 14. Date _____

DMS Approved: December 7, 2020

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:

Gainwell Technologies
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

Figure 5: Cash Refund Documentation

Gainwell Technologies

Mail To: Gainwell Technologies
P.O. Box 2108
Frankfort, KY 40602-2108
ATTN: Financial Services

Make checks payable to:
Kentucky State Treasurer

CASH REFUND DOCUMENTATION

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

Research for Refund: (Check appropriate blank)

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

☐ b. Billed in error

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

☐ d. Processing error OR overpayment (explain why)

☐ e. Paid to wrong provider

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

☐ g. Other

Contact Name _____ Phone _____

DMS Approved: March 6, 2020

5.9 Return to Provider Letter

Claims and attached documentation received by Gainwell 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
- EOMB for Medicare or Medicare Part C (Medicare Advantage)/Medicaid crossover claims

Other reasons for return may include:

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

Figure 6: Return to Provider Letter

gainwell

RETURN TO PROVIDER LETTER

Date: _____-_____-_____

Dear Provider,

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

01) _____ PROVIDER – A valid 8-digit Medicaid provider number or 10-digit NPI must be on the claim form in the appropriate field.
_____ Missing 33 A/B _____ Not a valid provider number _____ Qualifier missing/invalid field 33b _____ Field 33 A/B Invalid

02) _____ Provider Signature

03) _____ Detail lines exceed the limit for the claim type

04) _____ UNABLE TO IMAGE OR KEY - Claim form/Medicare coding sheet must be legible. Highlighted forms are not acceptable. White paper only, No shrunken claims, Blue or Black ink only, Front page only.

____ Print too light or dark ____ Front Page only ____ Highlighted fields ____Not legible ____Claim alignment/shrunken

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

06) _____ The Member's Medicaid (MAID) number is missing or invalid

_____ Missing _____Invalid

07) _____ Medicare Coding sheet does not match the claim _____One code sheet per claim

_____ Member Number _____ Member Name _____ Coding Sheet Details must match claim details/numbers

08) _____Other Reasons _____Incorrect form (claim/code sheet) _____Missing Medicaid payer name FL 50

_____No abbreviations for Payer Name in FL 50 (Medicare/Medicaid) _____Only one Medicaid/Medicare payer FL 50

_____ Member info missing (field 20) _____Dollar amount invalid on claim and/or Code Sheet

_____

_____

_____

_____ Claim(s) 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 must be entered in Field 1A
- The Member's Medicaid number on the UB04 must be entered in Block 60
- Member 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, Monday through Friday, 8:00 am until 6:00 pm eastern standard/daylight savings time, at 800-807-1232. **Electronic billing is strongly encouraged. You now have the capability to submit attachments electronically. If you are interested in billing Medicaid electronically, please contact Gainwell Technologies at 1-800-205-4696 7:30 AM to 6:00 PM Monday through Friday except holidays or view our training video on www.kymmis.com under Provider Relations, Training Videos.**

Clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Contacts and Assigned Counties

Table 1: Contacts and Assigned Counties

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

Note: Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.

Provider Relations contact number: 1-800-807-1232

6 Completion of UB-04 Paper Claim Form with NPI

6.1 UB-04 Billing with NPI Instructions

Following are form locator numbers and form locator instructions for billing hospital services on the UB-04 billing form. Only the instructions for form locators required for Gainwell processing or for KY Medicaid Program information are included. Instructions for Form Locators not used by Gainwell or the KY Medicaid Program can be found in the UB-04 Training Manual. The UB-04 Training Manual may be obtained from the address listed below. You may also obtain the UB-04 billing forms from the address listed below.

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

The original UB-04 billing form must be sent to:

Gainwell Technologies
P.O. Box 2106
Frankfort, KY 40602-2106

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.

6.2 UB-04 Claim Form with NPI and Taxonomy

Figure 7: UB-04 Claim Form with NPI and Taxonomy

1 Provider Name
Street Address
City or Town ST ZIP
AC+Phone Number
2
3a PAT. CNTL # Patient Control Number
b. MED. REC. #
4 TYPE OF BILL 0111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010107 THROUGH 013107
7
8 PATIENT NAME a
b
9 PATIENT ADDRESS a
b c d e
10 BIRTHDATE 01021900
11 SEX
ADMISSION 12 DATE 010107 13 HR 01 14 TYPE 1 15 SRC
16 DHR 13
17 STAT 01
CONDITION CODES 18 c1 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE 11 DATE 010107
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
a 80 30
b
c
d
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	120	ROOM CHARGES			30	30,000 00		
2	250	PHARMACY			98	688 00		
23	0001	PAGE ____ OF ____	CREATION DATE		TOTALS	30,688.00		

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

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

63 TREATMENT AUTHORIZATION CODES
A 01234567
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 234.5
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX 234.5
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE 123.4 DATE 010207
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI Attending NPI# QUAL
LAST JONES FIRST JAMES
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC National Uniform Billing Committee
LIC9213257

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

6.3.1 Detailed Instructions

Included is a representative sample of codes and/or services that may be covered by KY Medicaid:

Table 2: UB-04 Claim Form Field Descriptions

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
1	**Provider Name, Address, and Telephone** Enter the complete name, address, and telephone number (including area code) of the facility.
3	**Patient Control Number** Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.
4	**Type of Bill** Enter the code indicating the specific type of bill. This four-digit code requires a leading zero plus one digit from each of the four categories, written in the following sequence: • First position – Zero • Second position – Type of Facility • Third position – Bill Classification • Fourth position – Frequency • A current list of type of bill codes is available from the NUBC by subscription. See the NUBC website at nubc.org. The NUBC maintains this code set, which is considered an external code set by HIPAA requirements. Therefore, Kentucky Medicaid is not responsible for updating the type of bill code set. It is the provider's responsibility to monitor the changes made to this external code set. See examples below: **Claim Type** / **TOB** / **Comment** Inpatient / 0110 / Use when mom and newborn are in the same facility. DRG newborn claims to use TOB 0111. Inpatient and Medicare Inpatient Crossover / 0111, 0112, 0113, 0114 / DRG claims use TOB 0111. Medicare Inpatient Crossover / 0121, 0122, 0123, 0124 / Medicare Part B Inpatient Services Outpatient and Medicare / 0131, 0134, 0141 /

<table>
<tr><th>FORM LOCATOR #</th><th>FORM LOCATOR NAME AND DESCRIPTION</th></tr>
<tr><td></td><td>Outpatient Crossover

Medicare Outpatient Crossover 0132, 0133

Medicare Outpatient Crossover 0851, 0852, 0853, 0854 Critical Access Hospitals</td></tr>
<tr><td>6</td><td>Statement Covers Period
FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).
THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).
Do not include days prior to when the member’s KY Medicaid eligibility period began.
The “FROM” date is the date of the admission if the member was eligible for the KY Medicaid benefits upon admission. If the member was not eligible on the date of admission, the “FROM” date is the effective date of eligibility.
The “THROUGH” date is the last covered day of the hospital stay.</td></tr>
<tr><td>10</td><td>Date of Birth
Enter the member’s date of birth.</td></tr>
<tr><td>12</td><td>Admission Date
Enter the date on which the member was admitted to the facility in numeric format (MMDDYY).</td></tr>
<tr><td>13</td><td>Admission Hour
Enter the code for the time of admission to the facility. The admission hour is required for both inpatient and outpatient services.
Code Structure
<table><tr><th>Code</th><th>Time A.M.</th><th>Code</th><th>Time P.M.</th></tr><tr><td>00</td><td>12:00 – 12:59 (midnight)</td><td>12</td><td>12:00 – 12:59 (noon)</td></tr><tr><td>01</td><td>01:00 – 01:59</td><td>13</td><td>01:00 – 01:59</td></tr><tr><td>02</td><td>02:00 – 02:59</td><td>14</td><td>02:00 – 02:59</td></tr><tr><td>03</td><td>03:00 – 03:59</td><td>15</td><td>03:00 – 03:59</td></tr><tr><td>04</td><td>04:00 – 04:59</td><td>16</td><td>04:00 – 04:59</td></tr><tr><td>05</td><td>05:00 – 05:59</td><td>17</td><td>05:00 – 05:59</td></tr><tr><td>06</td><td>06:00 – 06:59</td><td>18</td><td>06:00 – 06:59</td></tr><tr><td>07</td><td>07:00 – 07:59</td><td>19</td><td>07:00 – 07:59</td></tr><tr><td>08</td><td>08:00 – 08:59</td><td>20</td><td>08:00 – 08:59</td></tr></table></td></tr>
</table>

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
	09 09:00 – 09:59 21 09:00 – 09:59 10 10:00 – 10:59 22 10:00 – 10:59 11 11:00 – 11:59 23 11:00 – 11:59
14	**Admission Type** Enter the appropriate type of admission: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn
16	**Discharge Hour** Enter the code for the hour the member was discharged from the facility using the code structure described for Field 13 (above).
17	**Patient Status Code** Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the "through" date in Form Locator 6. **Status Codes Accepted by KY Medicaid** **Code** **Description** 01 Discharged to Home/Self Care 02 Discharged to Another Hospital 03 Discharged to Skilled Nursing Facility (SNF) 04 Discharged to Intermediate Care Facility (ICF) 05 Discharged/Transferred to a Designated Cancer Center or Children's Hospital 06 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization 07 Left Against Medical Advice 10 Discharged/Transferred to a Psychiatric Hospital (end date 10/1/22) 20 Expired 21 Discharge or Transfer to Court/Law Enforcement 30 Still a Patient 40 Expired at Home 41 Expired in a Medical Facility 42 Expired – Place Unknown 50 Discharged to Hospice – Home 51 Discharged to Hospice Medical Facility 61 Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (valid on crossover claims only)

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
	62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital 63 Discharged/Transferred to a Medicare Certified Long Term Care Facility 65 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a Hospital 70 Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere 82 Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission 83 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission 85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission 86 Discharged/Transferred to Home under care of Organized Home 90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission 91 Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission 93 Discharged/transferred to a psychiatric hospital/distinct part unit of a hospital with a planned acute care hospital inpatient readmission
18-28	**Condition Codes** Peer Review Organization (PRO) Indicator Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee. C1 = Approved as Billed C2 = Automatic Approval as Billed Based on Focus Review C3 = Partial Approval* *If the PRO authorized a portion of the member's hospital stay, the approved date(s) must be shown in Form Locator 36, Occurrence Span. These dates should be the same as the dates of service in Form Locator 6. The condition codes are also included in the UB-04 Training Manual. Information regarding the Peer Review Organization is located in the Reference Index.

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
31-34	**Occurrence Codes and Dates** Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes. Accident Related Codes: 01 = Auto Accident 02 = No Fault Insurance Involved – Including Accident or Other 03 = Accident – Tort Liability 04 = Accident – Employment Related 05 = Accident - No Medical or Liability Coverage **Discharge Code and Date** Enter “42” and the actual discharge date when the “THROUGH” date in Form Locator 6 is not the actual discharge date and Form Locator 4 indicates “Final Bill.”
35-36	**Occurrence Span Code and Dates** Enter occurrence span code “MO” and the first and last days approved by the PRO/UR when condition code C3 (partial approval) has been entered in Form Locators 18-28.
37	**Medicare EOMB Date** Enter the EOMB date from Medicare or Medicare Part C (Medicare Advantage), if applicable.
39-41	**Value Codes** 80 = Covered Days Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. Covered days are not required for Medicare crossover claims for coinsurance days or life reserve days. 82 = Coinsurance Days Enter the number of coinsurance days billed to KY Medicaid during this billing period. 83 = Life Time Reserve Days Enter the Lifetime Reserve days the patient has elected to use for this billing period. A1 = Deductible Payer A Enter the amount as shown on the EOMB to be applied to the member’s deductible amount due. A2 = Coinsurance Payer A Enter the amount as shown on the EOMB to be applied toward the member’s coinsurance amount due.

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
	A7 = Copayment Payer A Enter the amount as shown on the EOMB to be applied to the member's Medicare Part C copayment amount due. B1 = Deductible Payer B Enter the amount as shown on the EOMB to be applied to the member's deductible amount due. B2 = Coinsurance Payer B Enter the amount as shown on the EOMB to be applied toward the member's coinsurance amount due. B7 = Copayment Payer B Enter the amount as shown on the EOMB to be applied to the member's Medicare Part C copayment amount due.
42	**Revenue Codes** Enter the three-digit revenue code identifying specific accommodation and ancillary services. A list of revenue codes covered by KY Medicaid is located in Appendices B and C of this manual. It is extremely important that the ancillary services reported on the UB-04 billing form be submitted by using the correct Revenue Codes. All approved Revenue Codes are listed in Appendices B and C of this manual. Incorrect billing of ancillary services or failure to correct any remarks may ultimately affect the instate provider's prospective payment rate. **Note**: Total charge Revenue code 0001 must be the final entry in column 42, line 23. **Note**: The total charge amount must be shown in column 47, line 23.
43	**Description** Enter the standard abbreviation assigned to each revenue code. A hospital shall include the corresponding National Drug Code (NDC) when billing a physician administered drug in the outpatient hospital setting. An NDC is required when billing outpatient services for revenue codes 250-253, 256-259, and 634-636. Revenue codes 254 and 255, and pharmaceutical or radiopharmaceutical contrast media, are exempt from an NDC requirement. The N4 qualifier precedes the NDC. Do not use dashes or spaces. Example: N4XXXXXXXXXX. Enter only one NDC per line.

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
44	**CPT/RATES** Outpatient claims require a CPT-4 procedure code to be billed only in conjunction with the revenue codes below. Revenue codes 300 – 314, 360, 430, 450, 452, 456, 481, 682, 683, 684, and 900 require a CPT-4 code. Revenue code 260 requires a CPT-4 effective 11/09/2020. NOTE: Outpatient claims billed with Procedure codes M0239, M0243, or Q0239 must be billed with Revenue code 260. Revenue code 771 requires a CPT-4 effective 12/11/2020. Effective March 25, 2024: H0038 – Peer Support Services are allowed in a hospital outpatient setting only and can be billed with any revenue code except 360, 481, and 900. Revenue code 900 also requires the use of one of the following modifiers: **Modifiers** — **Descriptions** AH — Licensed Clinical Psychologist AJ — Licensed Clinical Social Worker AM — Physician (MD or DO) HO — LPCC, LPAT, LBA SA — ARNP U1 — Physician Assistant U4 — Associate to the Behavioral Health Providers – CSW, LPCA, LPA, LPATA, LABA, LMFTA U9 — Licensed Marriage and Family Therapist UA — Certified Professional Counselor RT — Right Side (used to identify procedures performed on the right side of the body) LT — Left Side (used to identify procedures performed on the left side of the body) Modifier GT is applicable to the following services in an outpatient setting: Medical Nutrition Therapy, Individual Diabetes Self-Management Training, Physical Therapy, Speech Therapy, Occupational Therapy, End–Stage Renal Dialysis Monitoring, Assessment or Counseling for Home Dialysis, Physical Health Evaluation, Mental Health Evaluation, Individual or Group Psychotherapy, Pharmacologic Management, Psychiatric or Psychological, or Mental Health Diagnostic Interview, and Neurobehavioral Status Exam **Note:** For outpatient hospitals billing MRI – 73718, please bill with RT & LT modifiers on the same line along with 2 units.
45	**Detail Date of Service** Effective 08/01/2005, all outpatient claims require a detail date of service.

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
45	**Creation Date** Enter the invoice date or invoice creation date.
46	**Unit** Enter the quantitative measure of services provided per revenue code. Revenue Code 762 – Observation Room is measured as one unit and is equal to 23 hours or less.
47	**Total Charges** Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry “total charges.” The claim total must be shown in field 47, line 23.
48	**Non-Covered Charges** Enter the charges from Form Locator 47 that is non-payable by KY Medicaid.
50	**Payer Identification** Enter the names of payer organizations from which the provider receives payment. For Medicaid, use *KY Medicaid*. All other liable payers, including Medicare or Medicare Part C (Medicare Advantage), must be billed first.* *KY Medicaid is the payer of last resort. **Note**: If you are billing with a primary carrier being a Medicare Part C (Medicare Advantage) policy, “Medicare” needs to be indicated in the payer name field along with the name of the Medicare C (Medicare Advantage) policy carrier. Example: Medicare United Healthcare or United Healthcare Medicare.
54	**Prior Payments** Enter the paid amount from Medicare or Medicare Part C, if applicable. Enter the amount paid, if any, by private insurance.
56	**NPI** Enter the Pay To National Provider Identifier (NPI) number.
57	**Taxonomy** Enter the Pay To Taxonomy number.
57B	**Other** Enter the facility’s zip code.
58	**Insured’s Name** Enter the member’s name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the member’s name exactly as it appears on the member identification card in last name, first name, and middle initial format.

<table>
<tr><th>FORM LOCATOR #</th><th>FORM LOCATOR NAME AND DESCRIPTION</th></tr>
<tr><td>60</td><td>Identification Number
Enter the member identification number in Form Locators 60 A, B, and C that relates to the member’s name in Form Locators 58 A, B, and C. Enter the 10-digit member identification number exactly as it appears on the member identification card.</td></tr>
<tr><td>63</td><td>Prior Authorization Number
Enter the prior authorization number assigned by the PRO/UR designating that the treatment covered by the bill is authorized by the PRO/UR.</td></tr>
<tr><td>66</td><td>Diagnosis Indicator
Enter the appropriate International Classification of Diseases (ICD) indicator:
9= ICD 9
0 = ICD 10</td></tr>
<tr><td>67</td><td>Principal Diagnosis Code*
Enter the ICD-10 Vol. 1 and 2 codes describing the principal diagnosis.
*Effective dates of service July 1, 2010 and after, DRG facilities must indicate whether each diagnosis was present at the time of admission. Refer to the Present on Admission (POA) Indicators in the table below. The POA Indicator should follow the diagnosis code (in the shaded area in each field).
<table>
<tr><th>POA</th><th>Description</th></tr>
<tr><td>Y (for yes)</td><td>Present at the time of inpatient admission.</td></tr>
<tr><td>N (for no)</td><td>Not present at the time of inpatient admission.</td></tr>
<tr><td>U (for unknown)</td><td>The documentation is insufficient to determine if the condition was present at the time of inpatient admission.</td></tr>
<tr><td>W (for clinically undetermined)</td><td>The provider is unable to clinically determine whether the condition was present at the time of admission.</td></tr>
<tr><td>1 (one) (for unreported / not used)</td><td>Diagnosis is exempt from POA reporting.
Note: The International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-10) Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting. Use POA indicator 1 only for codes on the list.</td></tr>
</table></td></tr>
<tr><td>67A-Q</td><td>Other Diagnosis Code
Note: Refer to instructions for field 67 for a table of Present on Admission (POA) indicators.
Enter the ICD-10 Vol. 1 and 2 codes that co-exist at the time the service is provided.</td></tr>
<tr><td>69</td><td>Admitting Diagnosis (Inpatient Only)
Enter the ICD-10 diagnosis code describing the admitting diagnosis.</td></tr>
</table>

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
70	**New Patient Status Discharge** Discharges to transfers to other types of health care institutions not defined elsewhere in the UB-04 manual code list.
74	**Principal Procedure Code and Date** Enter the ICD-10 (Vol.3) procedure code that identifies the principal obstetrical or surgical procedure performed during the billing period. Enter the date the procedure was performed in numeric format (MMDDYY).
74A	**Other Procedure Code(s) and Date(s)** Enter the ICD-10 (Vol.3) procedure codes identifying the procedures, other than the principal obstetrical surgical procedure, performed during the billing period. Enter the date the procedures were performed in numeric format (MMDDYY).
76	**Attending Physician ID** Enter the Attending Physician NPI number.
77	**Operating** Enter the Operating Physician NPI number.
78	**Other (NPI)** Enter DN (to denote referring) and the Referring Physician NPI number, if applicable.
80	**Remarks** Enter the Attending Physician taxonomy, if applicable.

6.4 Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KY Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the KY Medicaid Program. Refund checks shall be made payable to "KY State Treasurer" and sent immediately to:

Gainwell Technologies
P.O. Box 2108
Frankfort, KY 40602-2108
ATTN: Financial Services Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse and those who do not refund a duplicate or inappropriate payment may be prosecuted.

7 Special Billing Instructions

7.1 DRG

Effective April 1, 2003, DRGs were implemented for inpatient claims. For any related outpatient services that are provided 72 hours before an inpatient admission, the outpatient service revenue codes are then added to the inpatient claim. Field 6 of the claim should reflect the true admission date of the inpatient claim. In the event that an outpatient service is performed and inpatient admission is required within 72 hours and the services are not related, there will be both an outpatient claim and an inpatient claim.

7.1.1 Instructions on Submitting a Multiple Page UB-04

Some billing situations may require multiple page UB-04 billing forms to incorporate all revenue codes. Indicate the **001** revenue code (Total Charge) as the last entry only on the last UB-04 billing form.

Contact Gainwell Provider Relations at 1-800-807-1232 for further assistance.

7.2 Incarcerated Members

The Kentucky Department for Medicaid Services (DMS) only reimburses hospital stays for incarcerated individuals who are admitted inpatient and meet all medically necessary criteria.

The presenting correctional institution is liable for all outpatient medical claims for a Kentucky Medicaid Member.

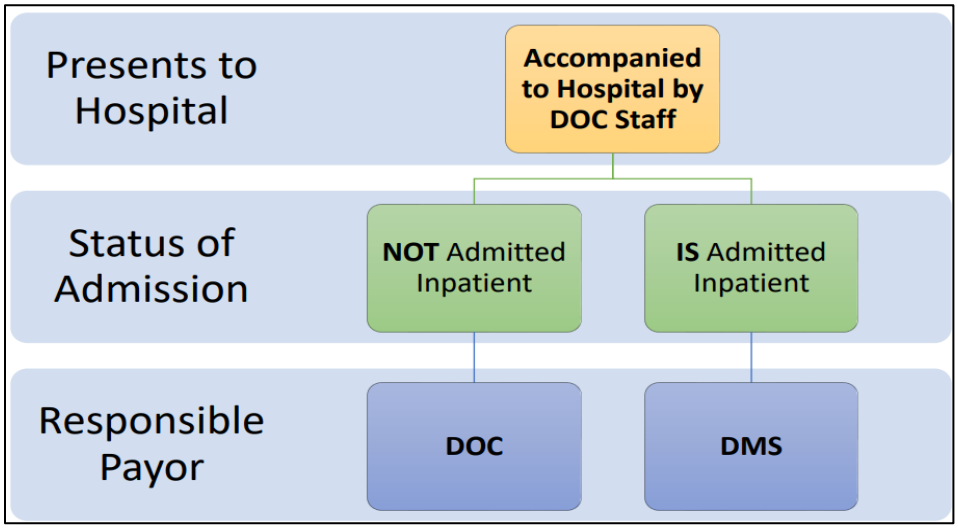
Steps for submitting an inpatient claim for an incarcerated member

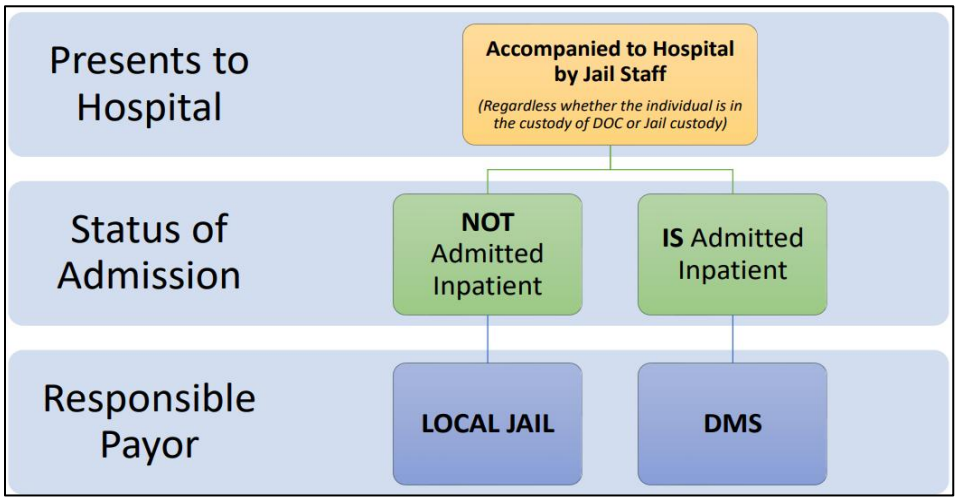
- Check patients' eligibility in KY Health Net.
    - The member must have **traditional Medicaid**
    - The ***Benefit Plan*** must be **Global Choices**.
    - ***Program Code*** must be **I3**

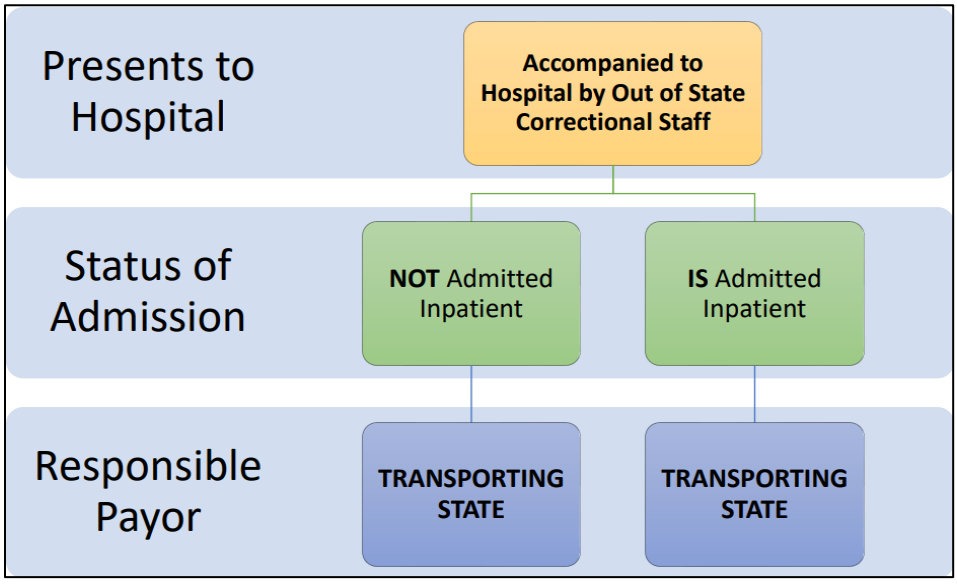
Determining Responsible Payor for Incarcerated Individuals Hospitalization

- The proceeding Decision Tree is not all inclusive and should be utilized as a guide for determining the responsible payor for incarcerated individuals that present to a Kentucky hospital.
- Individuals are considered incarcerated at the time of their detainment or arrest.
- The Kentucky Department for Medicaid Services (DMS) only reimburses hospital stays for incarcerated individuals who are admitted inpatient and meet all medically necessary criteria.
- The presenting correctional institution is liable for all outpatient medical claims for a Kentucky Medicaid Member.

Figure 8: Determining Responsible Payor for Incarcerated Individuals Hospitalization Flowchart







7.3 Cell and Gene Therapy (CGT) Access

DRG hospitals submitting claims for Cell and Gene Therapy drug charges will submit these charges on an outpatient hospital claim with the appropriate pharmacy revenue code, procedure code, and National Drug Code (NDC). An invoice showing the drug therapy cost must be attached to the claim and the claim billed amount must match the invoice cost. These claims must be submitted on paper and mailed to the Department for Medicaid Services for special handling. These should not be mailed directly to Gainwell.

7.4 Medicaid Payment for Claims

7.4.1 With Non-Covered Days Involving a Third Party

Admissions involving a payment from a third-party payer must be submitted with an itemized or summarized bill attached to the UB-04 billing form for admissions which contain non-covered Medicaid days.

The first 14 covered days of the admission are indicated in Form Locator 6, with the total days of 14 shown in Form Locator 7. The discharge day is indicated in Form Locator 32, by using Occurrence Code 42 and entering the date of discharge. The charges submitted to KY Medicaid for payment would be those charges incurred within the **Statement Covers Period**.

Claims meeting the requirements for KY Medicaid payment are paid in the following manner if a third-party payment is identified on the claim:

- The amount paid by the third party shall be applied to any non-covered days or services and any remaining monies shall reduce KY Medicaid payment
- If the third-party payment exceeds the Medicaid allowed amount, the resulting KY Medicaid payment shall be ZERO
- Members cannot be billed for any difference in covered charges and the KY Medicaid payment amount
    - All providers have the choice of determining if this type of service shall be billed to the Medicaid Program
- If KY Medicaid is billed for the service, the Medicaid guidelines shall be followed
    - Providers shall accept Medicaid payment as payment in full

Detailed below are sample Medicaid payment methodologies for in state and out-of-state inpatient hospital services. These payment formulas can be used to determine the amount due on any inpatient admission greater than fourteen days with third party involvement.

EXAMPLE 1: Pricing example for in-state hospitals using a per diem rate:

Step 1	$ 470.33	Medicaid Per Diem Rate
	X 14	Days Payable
	$6,584.62	Medicaid Maximum Payment
Step 2	$36,592.11	Total charges for 24 day stay (entire stay)
	-25,150.67	Billed charges for covered period
	$11,441.44	TPL Balance
	-11,913.10	Amount received from other source
	-471.66	TPL balance. If this amount is negative, Medicaid payment is reduced. If the amount is positive, Medicaid payment is not reduced.
Step 3	$6,584.62	Amount Payable
	-471.66	TPL Balance
	$6,112.96	Amount due from Medicaid Program

EXAMPLE 2: Pricing example for out-of-state hospitals using percentage of charges:

Step 1	$20,550.00	Billed charges for 14 days covered period
	- 200.00	Non-covered charges
	$20,350.00	Covered charges for days payable
	x 75%	Reimbursement rate
	$15,262.50	Medicaid Maximum payment
Step 2	$36,000.00	Total charges for total stay (20 days)
	-20,550.00	Total charges for covered stay
	$15,450.00	
	-19,000.00	Amount received from other sources
	$-3,550.00	TPL Balance. If this amount is negative, Medicaid payment is reduced. If the amount is positive, Medicaid payment is not reduced.
Step 3	$15,262.50	Medicaid maximum payment
	- 3,550.00	TPL balance
	$11,712.50	Amount due from Medicaid if paid using percentage as rate.
Step 4	The computed payment is compared against the maximum rate for in-state hospitals of comparable bed size using the payment formula for instate hospitals. The final Medicaid payment will be the lower of the two formulas.	

NOTE: If there is no third-party involvement, only Step 1 is necessary under either payment formula.

If the claim for a member is payable by a third-party resource which was not pursued by the provider, the claim shall be denied. Along with a third-party insurance company denial explanation, the name and address of the insurance company, name of the policy holder, and policy number are indicated on the remittance statement. The provider shall pursue payment with the third-party resource before billing Medicaid again. Itemized statements shall be stamped **"MEDICAID ASSIGNED"** when they are forwarded to insurance companies, attorneys, members, and so on.

8 Medicare or Medicare Part C (Medicare Advantage) Deductibles, Coinsurance, and Copays

Billing for Medicare Part A deductible or coinsurance days, Medicare Part B deductible or coinsurance and Medicaid services must be on separate claim forms. If the Member was covered by Medicare Part A, Medicare Part B, and Medicaid, three separate claims must be submitted for payment for the three types of benefits.

Medicaid PRO certification is not required on Medicare deductible and coinsurance claims as certification is determined using Medicare guidelines. If all Medicare benefits are exhausted and Medicaid days are being billed to Medicaid, PRO certification for Medicaid days is required.

Should the claim not appear on the KY Medicaid remittance advice 30 days following the Medicare adjudication date, submitting a claim via the KY HealthNet is recommended or you may submit a paper claim. All Medicare denials should be billed on paper, with the Medicare EOMB attached.

- Medicaid inpatient claims require prior authorization unless Medicare A or equivalent Medicare C policy processes the claim with coinsurance or deductible due.

- In some member eligibility cases, coverage can change from one KY Medicaid member benefit package to another KY Medicaid member benefit package during an outpatient crossover claim span of dates billed. When this happens, the OUTPATIENT hospital crossover claim billed as secondary after Medicare or Medicare C must be split-billed to match the member eligibility file.

  Example: A crossover claim for service dates 01/01/2026 through 01/31/2026 is sent to KY Medicaid as a secondary payer after Medicare or Medicare C. The KY Medicaid member is eligible under the Global Choices plan from 01/01/2026 to 01/17/2026 and is then moved into a Comprehensive Choices plan from 01/18/2026 to 01/31/2026. The outpatient crossover claim must then be split-billed to match the KY Medicaid package dates. The coinsurance due as well as the Medicare or Medicare C paid amount should be prorated to show the appropriate amount on each claim. If deductible is due, that amount should be shown on the first claim date (01/01/2026 – 01/17/2026) submitted to KY Medicaid.

8.1 Professional Fees

Effective September 1, 2002, professional fees are billed on a CMS 1500 (02/12) form under the attending physician’s individual provider ID for Emergency Room Services provided.

9 Medicare Part B Only

In the case a Medicaid Member has Medicare Part B only for an inpatient hospital stay, follow the billing rules below.

Utilize KYHealthNet Member Eligibility Verification to verify the KY Medicaid Member files show the member with Medicare B only (and no Medicare A).

On the same panel verify what type of coverage the member has with KY Medicaid.

- If the KY Medicaid member is shown in the MEDICARE SAVINGS POLICY with Program Code Z- QMB Only then KY Medicaid is only paying the patients Medicare premium, coinsurance and/or deductible after Medicare. If you are unable to bill Medicare for any reason (or if Medicare denies your claim), KY Medicaid will also deny your claim.

If the KY Medicaid policy is Comprehensive Choices, Optimum Choices, Family Choices, or Global Choices then follow the billing rules shown below.

- Patient has no Medicare A shown on file when KY Medicaid Member eligibility is checked but does have Medicare B.
- For an inpatient claim, bill Medicare B using type of bill 121 with the charges payable by Medicare B. Upon completion of processing, Medicare will cross over that claim to KY Medicaid.
- Once KY Medicaid has paid the type of bill 121, then bill the charges normally covered by Medicare A to KY Medicaid with a type of bill 111. This claim will require Inpatient Prior Authorization, will have no charges billable to Medicare B shown on the claim, and will have only KY Medicaid as the payer.

10 Form Requirements

Forms required for reimbursement of hospital services include, but may not be limited to, the following:

- Certification of Premature Birth (MAP-236)
- Other Hospitalization Form (MAP-383)

and

- Other Services Statement (MAP-397)

Claims and required forms completed incorrectly and submitted to KY Medicaid will result in denial of payment. All forms should be completed according to Medicaid guidelines as outlined in the following instructions. Situations involving crossover claims from Medicare or Medicare Part C (Medicare Advantage) will require the UB-04 billing form, Medicaid required form, and EOMB for processing.

Effective for date of service July 1, 2003, hospitals will no longer require the Certification for Abortion or Miscarriage (MAP 235), the Hysterectomy Consent Form (MAP 251), or the Sterilization Consent Form (MAP 250) for claims processing.

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

Figure 9: 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 professioanl 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

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

The table below provides a description of each form field to aid in its completion:

Table 3: Certification for Induced Premature Birth Form (MAP-236) Field Descriptions

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

10.2 Example of Other Hospitalization Statement Form (MAP-383)

Figure 10: Other Hospitalization Statement Form (MAP-383)

MAP-383 (Rev. 10/91)

OTHER HOSPITALIZATION STATEMENT

This is to certify that hospitalization at

_____
Name of Facility

for _____ beginning on
Recipient Name/MAID Number

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

The reason for this admission is _____/_____
Diagnosis ICD 9 CM Code

This patient's terminal illness is _____/_____
Diagnosis ICD 9 CM Code

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

Signed: _____
Medical Director

_____
Hospice Agency

_____
Date

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

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

If no, dates of previous admission _____

Diagnosis for previous admission _____
ICD 9 CM Code

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

_____
Medicaid Signature Date

10.3 Completion of Other Hospitalization Statement Form (MAP-383)

The table below provides a description of each form field to aid in its completion:

Table 4: Other Hospitalization Statement Form (MAP-383) Field Descriptions

Field	Description
Name of Facility	Enter the name of the facility where other hospitalization occurs.
Member Name / Member Identification Number	Enter the name and 10-digit member identification number of the member.
Date of Admission	Enter the date of the admission.
Medical Director	The signature of the Medical Director of the member's hospice agency is required.
Hospice Agency	Enter the name of the hospice agency.
Date	Enter the date this form was signed.

10.4 Example of Other Services Statement (MAP-397)

Figure 11: Other Services Statement (MAP-397)

MAP-397 (Rev. 6/91)

Other Services Statement

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

_____

Name of Agency

for _____ beginning on

Member Name/MAID Number

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

Date

of this patient.

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

Diagnosis ICD 9 CM Code

The patient's terminal illness is _____/_____

Diagnosis ICD 9 CM Code

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

Signed: _____

Medical Director

_____

Hospice Agency

_____

Date

☐ Durable Medical Equipment (List) _____

_____

_____

_____

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

_____

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

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

Yes ☐ No ☐

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

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

_____

ICD 9 CM Code

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

_____

Medicaid Signature Date

10.5 Completion of Other Services Statement (MAP-397)

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

Table 5: Other Services Statement (MAP-397) Field Descriptions

Item	Description
1	The name of the agency providing the service; the name, member identification number of the member, and the date of service must be entered in the appropriate spaces.
2	The ICD-10 code for the diagnosis must be entered.
3	The ICD-10 code describing the patient's terminal illness must be entered.
4	Items of durable medical equipment being billed separately must be specifically identified.
5	A description of hospital outpatient services and the reason for the services must be entered.
6	The form must be signed and dated by the medical director of the hospice agency.
7	Documentation verifying that the services are totally unrelated to the terminal illness of the member must be attached to the form.
8	All copies of the form must be submitted to Carewise Health, Inc. Two copies of the form will be returned to the provider signed by a KY Medicaid representative indicating whether separate payment for the services has been approved or denied.
9	If approved, one copy of the form must be sent to the provider who will bill for the service. The other copy should be retained by the hospice agency.

11 Appendix A – Internal Control Number

An Internal Control Number (ICN) is assigned by Gainwell 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:

$$\underset{1}{11} - \underset{2}{20} - \underset{3}{032} - \underset{4}{123456}$$

1. Region
   a. The *Region* in each ICN is the first set of numbers, which describes how the claim is received. The following table provides a description of each region:

Table 6: Internal Control Number, Region Codes and Descriptions

Region	Description
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
23	Internet Claims with 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

12 Appendix B – Inpatient Revenue Codes

Following is a representative sample list of the revenue codes that are accepted by KY Medicaid when billing for inpatient services on the UB-04 billing form:

Table 7: Inpatient Revenue Codes Field Descriptions

Inpatient Revenue Code	Description
001	Total Charges
100	All-Inclusive Room and Board Plus Ancillary
101	All-Inclusive Room and Board
110	Private Room-Board, General
111	Medical / Surgical / Gyn
112	OB
113	Pediatric
114	Psychiatric
115	Hospice
116	Detoxification
117	Oncology
118	Rehabilitation
120	Semi-Private Room and Board, General
121	Medical / Surgical / Gyn
122	OB
123	Pediatric
124	Psychiatric
125	Hospice
126	Detoxification
127	Oncology
128	Rehabilitation
130	Semi-Private (3-4 Bed) Room, General
131	Medical / Surgical / Gyn
132	OB

Inpatient Revenue Code	Description
133	Pediatric
134	Psychiatric
135	Hospice
136	Detoxification
137	Oncology
138	Rehabilitation
140	Deluxe Private Room, General
141	Medical / Surgical / Gyn
142	OB
143	Pediatric
144	Psychiatric
145	Hospice
146	Detoxification
147	Oncology
148	Rehabilitation
150	Room (Ward), General
151	Medical / Surgical / Gyn
152	OB
153	Pediatric
154	Psychiatric
155	Hospice
156	Detoxification
157	Oncology
158	Rehabilitation
160	Other Room and Board, General
164	Sterile Environment
170	Nursery, General
171	Newborn
172	Premature

Inpatient Revenue Code	Description
173	Room and Board Nursery III
174	Room and Board Nursery IV
175	Neonatal ICU (end dated 12/31/2015)
200	Intensive Care Room, General
201	Surgical
202	Medical
203	Pediatric
204	Psychiatric
206	Post ICU
207	Burn Care
208	Trauma
210	Coronary Care Room, General
211	Myocardial Infraction
212	Pulmonary Care
213	Heart Transplant
214	Post-CCU
230	Incremental Nursing, General
231	Nursery
233	ICU
234	CCU
240	All Inclusive Ancillary, General
250	Pharmacy
251	Generic Drugs
252	Non-Generic Drugs
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
256	Experimental Drugs
257	Non-Prescription
258	IV Solutions

Inpatient Revenue Code	Description
260	IV Therapy, General
261	Infusion Pump
264	IV Therapy/Supplies
270	Medical / Surgical Supplies and Devices, General
271	Non-Sterile Supply
272	Sterile Supply
274	Prosthetic Devices
275	Pace Maker
276	Intraocular Lens
278	Other Implants
280	Oncology, General
290	Minor Home Adapt / Environment Access
300	Laboratory, General
301	Chemistry
302	Immunology
303	Renal Patient (Home)
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology and Microbiology
307	Urology
310	Lab Pathology, General
311	Cytology
312	Histology
314	Biopsy
320	Radiology Diagnostic, General
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray

Inpatient Revenue Code	Description
330	Radiology-Therapeutic, General
331	Chemotherapy – Injected
332	Chemotherapy – Oral
333	Radiation Therapy
334	Chemotherapy Ed Cancer Hemophilia (End dated 8/12/2022)
335	Chemotherapy – IV
340	Nuclear Medicine, General
341	Diagnostic
342	Therapeutic
343	Radiopharmaceuticals, Diagnostic and Therapeutic
350	CT Scan, General
351	Head Scan
352	Body Scan
360	Operating Room, General
361	Minor Surgery
362	Organ Transplant – Other Than Kidney
367	Kidney Transplant
370	Anesthesia, General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
374	Acupuncture
380	Blood, General
381	Packed Red Cells
382	Whole Blood
383	Plasma
384	Platelets
385	Leukocytes
386	Other Components
387	Other Derivatives (Cryoprecipitate)

Inpatient Revenue Code	Description
390	Blood Storage and Processing, General
391	Blood Administration
400	Other Imaging Services, General
401	Diagnostic Mammography
402	Ultra Sound
403	Screening Mammography
404	Pet Scan
410	Respiratory Services, General
412	Inhalation Services
413	Hyper Baric Oxygen Therapy
420	Physical Therapy, General
421	Visit Charge
422	Hourly Charge
423	Group Rate
424	Evaluation or Re-Evaluation
430	Occupational Therapy, General
434	Evaluation or Re-Evaluation
440	Speech Therapy, General
441	Visit Charge
442	Hourly Charge
443	Group Rate
444	Evaluation or Re-Evaluation
450	Emergency Room, General
460	Pulmonary Function
470	Audiology, General
471	Diagnostic
472	Treatment
480	Cardiology, General
481	Cardiac Cath Lab

Inpatient Revenue Code	Description
482	Stress Test
483	Echo Cardiology
610	MRT, General
611	MRI Brain (Including Brainstem)
612	MRI Spinal Cord (Including Spine)
615	MRA, Head and Neck
616	MRA, Lower Extremities
618	MRA, Other
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
623	Surgical Dressings
634	Erythropoietin (EPO) Less Than 10,000 Units
635	Erythropoietin (EPO) 10,000 Or More Units
636	Drug Requiring Detailed Coding
700	Cast Room, General
710	Recovery Room, General
720	Labor Room/ Delivery, General
721	Labor
722	Delivery
723	Circumcision
724	Birthing Center
730	EKG / ECG, General
731	Holter Monitor
732	Telemetry (Includes Fetal Monitoring)
740	EEG, General
750	Gastro-Intestinal Services, General
780	Telemedicine (eff 02/04/2020)
790	Lithotripsy, General
800	Inpatient Renal Dialysis, General

Inpatient Revenue Code	Description
801	Inpatient Hemodialysis
802	Inpatient Peritoneal (Non-CAPD)
803	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
804	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
809	Inpatient Renal Dialysis/Other
810	Organ Acquisition, General
811	Living Donor
812	Cadaver Donor
813	Unknown Donor
814	Other Kidney Acquisition
815	Cadaver Donor – Heart
816	Other Heart Acquisition (end dated 12/31/2015)
817	Donor – Liver (end dated 12/31/2015)
890	Donor Bank, General (end dated 12/31/2015)
891	Bone (end dated 12/31/2015)
892	Organ (Other Than Kidney) (end dated 12/31/2015)
893	Donor Bank Skin (end dated 12/31/2015)
900	Psychiatric / Psychological Treatments, General
901	Electroshock Treatment
914	Psychiatric Services Individual Therapy (eff 1/1/2017)
915	Psychiatric Services Group Therapy (eff 1/1/2017)
920	Other Diagnostic Services, General
921	Peripheral Vascular Lab
922	Electromyogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
940	Other Therapeutic Services, General
942	Education/ Training

Inpatient Revenue Code	Description
943	Cardiac Rehabilitation
946	Complex Medical Equipment – Routine
947	Complex Medicaid Equipment – Ancillary
948	Pulmonary Rehabilitation
960	Pro Fees General
963	Anesthesiologist (MD)
971	Pathologist (MD)
972	Radiologist – Diagnostic (MD)
973	Radiologist – Therapeutic (MD)
974	Radiologist – Nuclear Medicine (MD)
985	Cardiologist – EKG (MD)
986	Cardiologist – EEG (MD)
997	Admission Kits

12.1 Incremental Nursing Revenue Codes

The following Incremental Nursing Revenue Codes listed in Column A cannot be reimbursed by the Medicaid Program unless they are billed in conjunction with the appropriate accommodation revenue codes in column B.

Table 8: Incremental Nursing Revenue Codes

A		B
230, 231	Can Only Be Reimbursed in Conjunction With	170-175
230, 233	Can Only Be Reimbursed in Conjunction With	200-208
230, 234	Can Only Be Reimbursed in Conjunction With	210-214

13 Appendix C – Outpatient Revenue Codes

The following is a list of the revenue codes that are reimbursable by KY Medicaid when billing for outpatient services on the UB-04 billing form:

Table 9: Outpatient Revenue Codes Field Descriptions

Outpatient Revenue Code	Description
250	Pharmacy
251	Drugs / Generic
252	Drugs / Non-Generic
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
258	IV Solutions
259	Other Pharmacy
260	IV Therapy, General
261	Infusion Pump
264	IV Therapy/Supplies
270	Medical / Surgical Supplies and Devices, General
271	Non Sterile Supply
272	Sterile Supply
274	Prosthetic Devices
275	Pace Maker
276	Intraocular Lens
278	Other Implants
280	Oncology, General
290	Minor Home Adapt / Environment Access
300*	Laboratory, General
301	Chemistry
302	Immunology
303	Renal Patient (Home)
304	Non-Routine Dialysis

Outpatient Revenue Code	Description
305	Hematology
306	Bacteriology and Microbiology
307	Urology
309	Other Laboratory
310	Lab Pathology, General
311	Cytology
312	Histology
314	Biopsy
320	Radiology Diagnostic, General
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray
330	Radiology – Therapeutic, General
331	Chemotherapy – Injected
332	Chemotherapy – Oral
333	Radiation Therapy
334	Chemotherapy Ed Cancer Hemophilia (end dated 12/31/2015)
335	Chemotherapy – IV
340	Nuclear Medicine, General
341	Diagnostic
342	Therapeutic
343	Radiopharmaceuticals, Diagnostic and Therapeutic
344	Radiopharmaceuticals, Diagnostic and Therapeutic
350	CT Scan, General
351	Head Scan
352	Body Scan
360	Operating Room, General
361	Minor Surgery

Outpatient Revenue Code	Description
370	Anesthesia, General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
374	Acupuncture
380	Blood, General
381	Packed Red Cells
382	Whole Blood
383	Plasma
384	Platelets
385	Leucocytes
386	Other Components
387	Other Derivatives (Cryoprecipitate)
390	Blood Storage and Processing, General
391	Blood Administration
400	Other Imaging Services, General
401	Diagnostic Mammography
402	Ultra Sound
403	Screening Mammography
404	Pet Scan
410	Respiratory Services, General
412	Inhalation Service
413	Hyperbaric Oxygen Therapy
420	Physical Therapy, General
421	Visit Charge
422	Hourly Charge
423	Group Rate
424	Evaluation or Re-Evaluation
430	Occupational Therapy (effective 07/04/2014)
434	Evaluation or Re-Evaluation

Outpatient Revenue Code	Description
440	Speech-Language Pathology, General
441	Visit Charge
442	Hourly Charge
443	Group Rates
444	Evaluation or Re-Evaluation
450	Emergency Room, General
451	Emergency Room
452	Emergency Roo
456	Emergency Room – Urgent Care
460	Pulmonary Function
470	Audiology, General
471	Diagnostic
472	Treatment
480	Cardiology, General
481	Cardiac Cath Lab
482	Stress Test
483	Echo Cardiology
510	Clinic, General
511	Clinic/Chronic Pain
512	Dental Clinic
516	Urgent Care Clinic
517	Family Practice Clinic
610	MRT, General
611	MRI, Brain (Including Brainstem)
612	MRI, Spinal Cord (Including Spine)
614	MRI/Other
615	MRA, Head and Neck
616	MRA, Lower Extremities
618	MRA, Other

Outpatient Revenue Code	Description
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
623	Surgical Dressings
634	Erythropoietin (EPO) Less Than 10,000 Units
635	Erythropoietin (EPO) 10,000 or More Units
636	Drug Requiring Detailed Coding
681	Trauma Response Level I
682	Trauma Level II
683	Trauma Level III
684	Trauma Level IV
700	Cast Room, General
710	Recovery Room, General
720	Labor Room / Delivery, General
721	Labor
722	Delivery
723	Circumcision
724	Birthing Center
730	EKG / ECG, General
731	Holter Monitor
732	Telemetry (Including Fetal Monitoring)
740	EEG, General
750	Gastro-Intestinal Service, General
760	Treatment / Observation Room
761	Treatment Room
762	Observation Room
771	Preventive Care Services; Vaccine Administration
780	Telemedicine (eff 02/04/2020)
790	Lithotripsy, General
817	Liver Acquisition (end dated eff 12/31/2015)

Outpatient Revenue Code	Description
820	Hemodialysis General
821	Hemodialysis Composite or other Rate
830	Peritoneal Dialysis General
831	Peritoneal Composite Rate
840	Continuous CAPO General
841	CAPD Composite or other Rate
845	CAPD Support Services
850	Continuous Cycling Dialysis CCPD General
851	CCPD Composite or other Rate
880	Miscellaneous Dialysis General
890	Donor Bank, General (end dated eff 12/31/2015)
891	Bone (end dated eff 12/31/2015)
892	Organ (Other Than Kidney) (end dated eff 12/31/2015)
893	Skin (end dated eff 12/31/2015)
900	Psychiatric Services, General
901	Electroshock Treatment
905	BH – Intensive OP Psych (eff 7/1/2018)
910	Psychiatric Services, General (effective 07/04/2014-6/30/2021) replaced with 900
914	Psychiatric Services Individual Therapy (eff 1/1/2017)
915	Psychiatric Services Group Therapy (eff 1/1/2017)
920	Other Diagnostic Services, General
921	Peripheral Vascular Lab
922	Electromyogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
940	Other Therapeutic Services, General
942	Other Therapeutic Services

Outpatient Revenue Code	Description
943	Cardiac Rehabilitation
948	Pulmonary Rehabilitation
963	Anesthesiologist (MD)
971	Pathologist (MD)
972	Radiologist – Diagnostic (MD)
973	Radiologist – Therapeutic (MD)
974	Radiologist – Nuclear Medicine (MD)
985	Cardiologist – EKG (MD)
986	Cardiologist – EEG (MD)
001	Total Charges

Effective July 1, 1994, Department for Medicaid Services implemented the ClaimCheck® auditing system for out-patient laboratory services. Revenue codes 300 – 319 are audited through this system.

14 Appendix D – Inpatient and Outpatient Professional Component

The following revenue codes (column A) are professional component revenue codes that cannot be reimbursed by the Medicaid Program unless they are billed in conjunction with the revenue codes in column B.

Table 10: Inpatient and Outpatient Professional Component

A		B
963	Can Only Be Reimbursed in Conjunction With	370 or 374
971	Can Only Be Reimbursed in Conjunction With	300 through 307 310 through 312 314 or 460
972	Can Only Be Reimbursed in Conjunction With	320 through 324 350 through 352 400 through 402 610 through 612 750, 790, and 920 through 925
973	Can Only Be Reimbursed in Conjunction With	330, 331, 332, 333, or 335
974	Can Only Be Reimbursed in Conjunction With	340 through 342 350 through 352
985	Can Only Be Reimbursed in Conjunction With	480 through 482 730, 731, or 943
986	Can Only Be Reimbursed in Conjunction With	320, 740

15 Appendix E – Outpatient Drugs

The following biological and blood constituents are the only drugs payable on the outpatient basis for services provided prior to July 1, 1990.

Table 11: Outpatient Drugs Revenue Codes and Biological and Blood Constituents

Revenue Code	Biological and Blood Constituents
258	Base IV Solutions (without Drug Additives)
270	Cortisone Injections
270	Rabies Drug Treatment
270	Tetanus Toxoid
303	Medications Associated with Renal Dialysis Treatment
331	Chemotherapy for Any Blood or Chemical Dyscrasia (for example, Cancer, Hemophilia)
387	Anti-hemophilia Factor (AHF)
387	Rho (D) Immune Globulin (Human)
636	Drugs Requiring Detailed Coding

Note: For services provided on or after July 1, 1990, KY Medicaid reimbursement is available for drugs (Revenue Codes 250 – 252) administered in the outpatient department. Reimbursement is not available for take home drugs or drugs which have been deemed less than effective by the Food and Drug Administration (FDA).

16 Appendix F – 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.

16.1 Examples of Pages in a 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:

Table 12: Remittance Advice Field Descriptions

Field	Description
Returned Claims	This section lists all claims that have been returned to the provider with a Return to Provider (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 it 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	EOB codes which appear in the RA are defined in this section.

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

16.2 Title

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

Figure 12: Remittance Advice Header

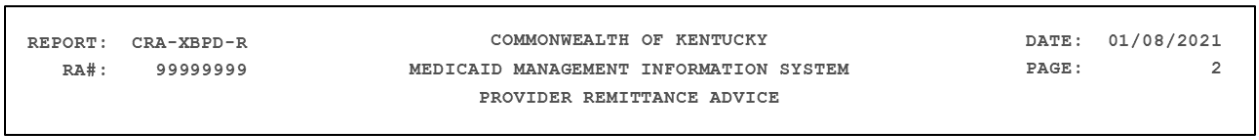


Table 13: Remittance Advice Header Field Descriptions

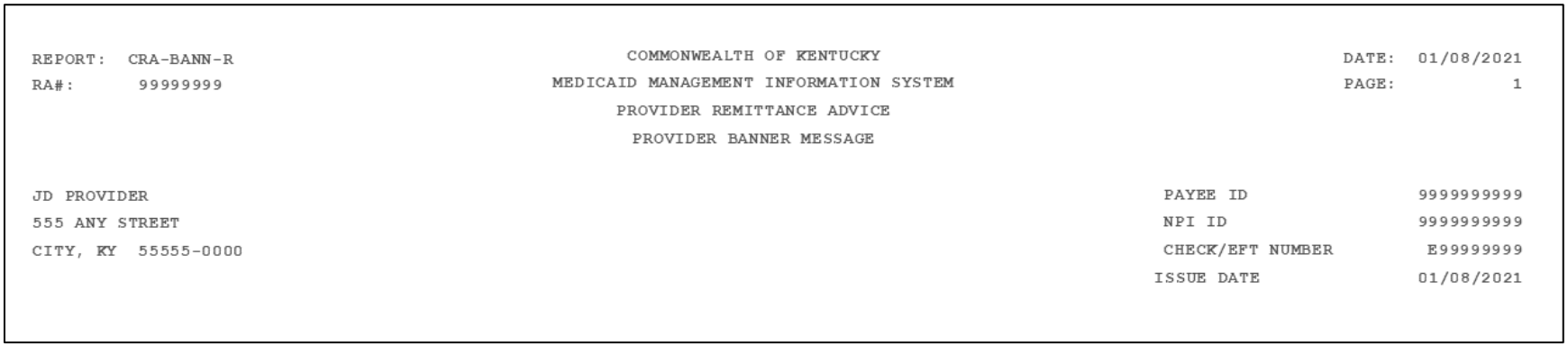
Field	Description
Date	The date the Remittance Advice was printed.
RA Number	A system-generated number for the Remittance Advice.
Page	The number of the page within each Remittance Advice.
Claim Type	The type of claims listed on the Remittance Advice.
Provider Name	The name of the provider that billed. (The type of provider is listed directly below the name of the 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.

16.3 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.

Figure 13: Provider Remittance Banner Page



```
REPORT:  CRA-BANN-R                  COMMONWEALTH OF KENTUCKY                    DATE:  01/08/2021
RA#:      99999999                MEDICAID MANAGEMENT INFORMATION SYSTEM        PAGE:           1
                                        PROVIDER REMITTANCE ADVICE
                                        PROVIDER BANNER MESSAGE

JD PROVIDER                                                      PAYEE ID            9999999999
555 ANY STREET                                                   NPI ID              9999999999
CITY, KY  55555-0000                                             CHECK/EFT NUMBER     E99999999
                                                                 ISSUE DATE          01/08/2021
```

Figure 14: Provider Remittance Advice UB04 Claims Paid

REPORT: CRA-IPPD-R
RA#: 99999999

COMMONWEALTH OF KENTUCKY
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB04 CLAIMS PAID

DATE: 01/08/2021
PAGE: 2

JD PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 9999999999
NPI ID 9999999999
CHECK/EFT NUMBER E99999999
ISSUE DATE 01/08/2021

--ICN-- / PAT. ACCT NUM.	ATTENDING PROV.	SERVICE DATES FROM	THRU	DAYS	ADMIT DATE	BILLED AMT	ALLOWED AMT	SPENDDOWN COPAY AMT	PATIENT LIABILITY	TPL AMT	PAID AMT
MEMBER NAME: JOHN DOE				MEMBER ID: 9999999999							
9999999999999	9999999999	122920	123120	2	122920	10,366.81	0.00	0.00		0.00	3,846.59
9999999999								0.00	0.00		

HEADER EOBS: 3001 9932

LN	REV CD	HCPCS/RATE	SRV DATE	DRG CODE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
0001	111		122920	0807	2.00	3,555.42	0.00	9932
0002	250		122920	0807	48.00	63.24	0.00	9932
0003	300		122920	0807	5.00	118.32	0.00	9932
0004	301		122920	0807	1.00	240.00	0.00	9932
0005	302		122920	0807	1.00	44.13	0.00	9932
0006	306		122920	0807	2.00	217.75	0.00	9932
0007	307		122920	0807	1.00	7.47	0.00	9932
0008	370		122920	0807	1.00	200.00	0.00	9932
0009	510		122920	0807	1.00	110.50	0.00	9932
0010	720		122920	0807	1.00	474.00	0.00	9932
0011	722		122920	0807	1.00	5,335.98	0.00	9932
				Total:	64.00	10,366.81	0.00	

16.4 Paid Claims Page

The table below provides a description of each field on the Paid Claims page:

Table 14: Paid Claims Page Field Descriptions

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 13-digit unique system-generated identification number assigned to each claim by Gainwell.
Attending Provider	The member's attending provider.
Claim Service Dates From – Thru	The date or dates the service was provided in month, day, and year numeric format.
Days	The number of days billed.
Admit Date	The admit date of the member.
Billed Amount	The usual and customary charge for services provided for the member.
Allowed Amount	The allowed amount for Medicaid.
Spenddown Copay Amount	The amount collected from the member.
TPL Amount	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
Paid Amount	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
Claims Paid on this RA	The total number of paid claims on the Remittance Advice.
Total Billed	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
Total Paid	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).

Figure 15: Provider Remittance Advice UB04 Claims Denied Report

REPORT: CRA-OPDN-R COMMONWEALTH OF KENTUCKY DATE: 01/08/2021
RA#: 99999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 80
PROVIDER REMITTANCE ADVICE
UB04 CLAIMS DENIED

JD PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 9999999999
NPI ID 9999999999
CHECK/EFT NUMBER E99999999
ISSUE DATE 01/08/2021

--ICN-- / --PATIENT NUMBER--	ATTEND PROV.	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JOHN DOE			MEMBER ID: 9999999999			
9999999999999 / 9999999999	9999999999	123120	123120	321.39	0.00	0.00

HEADER EOBS: 1784

LN	REV	CD HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	DETAIL EOBS
0001	352	73200	123120		1.00	321.39	
			Total:		1.00	321.39	

16.5 Denied Claims Page

The table below provides a description of each field on the Denied Claims page:

Table 15: Denied Claims Page Field Descriptions

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 Gainwell.
Attending Provider	The member's attending provider.
Claim Service Date From – Thru	The date or dates the service was provided in month, day, and year numeric format.
Days	The number of days billed.
Admit Date	The admit date of the member.
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.
Claim Pmt. Amt.	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
Claims Denied on this RA	The total number of denied claims on the Remittance Advice.
Total Billed	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).
Total Paid	The total dollar amount paid by Medicaid for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on the final page of section).

Figure 16: Provider Remittance Advice UB04 Claims in Process Report

```
REPORT:  CRA-HHSU-R                          COMMONWEALTH OF KENTUCKY                          DATE:   01/08/2021
 RA#:     99999999                   MEDICAID MANAGEMENT INFORMATION SYSTEM                  PAGE:          10
                                          PROVIDER REMITTANCE ADVICE
                                          UB04 CLAIMS IN PROCESS

JD PROVIDER                                                                    PAYEE ID          9999999999
555 ANY STREET                                                                 NPI ID            9999999999
CITY, KY  55555-0000                                                           CHECK/EFT NUMBER  E999999999
                                                                               ISSUE DATE        01/08/2021

   --ICN--      ATTEND PROV.            SERVICE DATES          BILLED          TPL       SPENDDOWN
   --PATIENT NUMBER--                    FROM     THRU         AMOUNT          AMOUNT      AMOUNT
MEMBER NAME: JOHN DOE                                  MEMBER  ID:  9999999999
 9999999999999      9999999999          120320 123020          345.60           0.00        0.00
   99999999999999999999
LN    REV CD HCPCS/RATE  SRV DATE  MODIFIERS       UNITS       BILLED AMT  DETAIL EOBS
0001  270    T4535       120320                   384.00          345.60  0505 9940
                                Total:            384.00          345.60
RELATED HISTORY - LINE    HISTORY ICN        DATE PAID
                    1     9999999999999      20201211
```

16.6 Claims in Process Page

The table below provides a description of each field on the Claims in Process page:

Table 16: Claims in Process Page Field Descriptions

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 Gainwell.
Attending Provider	The attending provider's NPI.
Claim Service Date From – Thru	The date or dates the service was provided in month, day, and year numeric format.
Days	The number of days billed.
Admit Date	The admit date of the member.
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.

Figure 17: Provider Remittance Advice Claims Returned Report

```
REPORT:   CRA-IPPD-R                  COMMONWEALTH OF KENTUCKY (M1)                    DATE:    01/08/2021
 RA#:      99999999                 MEDICAID MANAGEMENT INFORMATION SYSTEM            PAGE:           2
                                          PROVIDER REMITTANCE ADVICE
                                              CLAIMS RETURNED
                                                                          PAYEE ID          9999999999
JD PROVIDER                                                               NPI ID
555 ANY STREET                                                            CHECK/EFT NUMBER  E99999999
CITY, KY  55555-0000                                                      ISSUE DATE        01/08/2021

  -ICN--           REASON CODE
9999999999999         01




   CLAIMS RETURNED:   01
```

16.7 Returned Claim

The table below provides a description of each field on the Returned Claim page:

Table 17: Returned Claim Page Field Descriptions

Field	Description
ICN	The 13-digit unique system-generated identification number assigned to each claim by Gainwell.
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 returned via regular mail. The actual claim is returned with a “return to provider” sheet attached, indicating the reason for the claim being returned.

Figure 18: Provider Remittance Advice UB04 Claim Adjustments Report

```
REPORT:  CRA-IPAD-R                                    COMMONWEALTH OF KENTUCKY                                          DATE:   01/08/2021
  RA#:    99999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE:            18
                                                        PROVIDER REMITTANCE ADVICE
                                                          UB04 CLAIM ADJUSTMENTS

JD PROVIDER                                                                                                  PAYEE ID            9999999999
555 ANY STREET                                                                                               NPI ID              9999999999
CITY, KY  55555-0000                                                                                         CHECK/EFT NUMBER     E99999999
                                                                                                            ISSUE DATE           01/08/2021

     -PATIENT NUMBER.-        ICN              SERVICE DATES       BILLED         TPL   CO-PAY  SPENDOWN   PATIENT   PAID
                                                FROM    THRU        AMOUNT      AMOUNT   AMOUNT   AMOUNT  LIABILITY  AMOUNT

*** ADJUSTMENT TO CLAIM 9999999999999   ORIGINALLY PAID ON 20200522
   FOR MEMBER  JOHN DOE                                MEMBERID # 9999999999
   PROVIDED 042920  BILLED AMOUNT:    -95,258.30   PAID AMOUNT:   -12.841.68
ADJUSTMENT REASON: 8515    YOUR VOID TRANSACTION HAS BEEN PROCESSED.
*** NEW CLAIM   9999999999999
MEMBER NAME: JOHN DOE                            MEMBERID: 9999999999
 99999999999              9999999999999          042920  051220  -95,258.30        -0.00             -0.00             -0.00
                                                                                                  -0.00            -0.00
ADJUSTMENT REASON: 8515    YOUR VOID TRANSACTION HAS BEEN PROCESSED.
                                                                                          HEADER EOBS:  3001 8179 9932
LN    REV CD  PROC   DRG       QTY  SERVICE DATES    BILLED AMT   CO-PAY AMT   PAID AMT  EOBS
0001   200           0871     9.00  042920 051220     67,470.75         0.00       0.00  9932
0002   206           0871     4.00  042920 051220     14,784.96         0.00       0.00  9932
0003   250           0871   638.00  042920 051220      1,697.59         0.00       0.00  9932
0004   260           0871     1.00  042920 051220        534.69         0.00       0.00  9932
0005   300           0871   139.00  042920 051220      5,269.47         0.00       0.00  9932
0006   301           0871    59.00  042920 051220        681.62         0.00       0.00  9932
0007   306           0871     2.00  042920 051220        217.75         0.00       0.00  9932
0008   324           0871     2.00  042920 051220        355.92         0.00       0.00  9932
0009   450           0871     2.00  042920 051220      3,817.96         0.00       0.00  9932
0010   730           0871     2.00  042920 051220        355.92         0.00       0.00  9932
0011   940           0871     1.00  042920 051220        108.21         0.00       0.00  9932
NET EFFECT OF ADJ:          859.00                                     0.00                 0.00                -12,841.68
```

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for its 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.

16.8 Adjusted Claims Page

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

Table 18: Adjusted Claims Page Field Descriptions

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 Gainwell.
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.

Figure 19: Provider Remittance Advice Financial Transactions

```
REPORT:   CRA-TRAN-R                          COMMONWEALTH OF KENTUCKY                          DATE:  12/25/2020
 RA#:      99999999                         MEDICAID MANAGEMENT INFORMATION SYSTEM             PAGE:          157
                                                  PROVIDER REMITTANCE ADVICE
                                                   FINANCIAL TRANSACTIONS

JD PROVIDER                                                                          PAYEE ID            9999999999
555 ANY STREET                                                                       NPI ID              9999999999
CITY, KY  55555-0000                                                                 CHECK/EFT NUMBER     E99999999
                                                                                     ISSUE DATE          12/25/2020

                                          ---------------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS---------------
  TRANSACTION                    PAYOUT    REASON   RENDERING              SVC DATE
    NUMBER       --CCN--       --AMOUNT--  CODE    PROVIDER              FROM    THRU     MEMBER NO.    MEMBER NAME

                         NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS
                                        --------------- CLAIM SPECIFIC REFUNDS FROM PROVIDERS ---------------
                  REFUND      ICN                  REASON
    --CCN--       --AMOUNT--  REFUNDED             CODE    REASON DESCRIPTION

                         NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS
                                                 ---------------ACCOUNTS RECEIVABLE---------------
  A/R          SETUP      RECD/RECPD        ORIGINAL          A/R          TOTAL          INT          INT                REASON
NUMBER/ICN      DATE      THIS CYCLE          AMOUNT         INC/DEC      RECD/RECP       CALC         RECD     BALANCE    CODE

9999999999999  122520         44.49           44.49           0.00         44.49         -0.00         0.00       0.00     8400
     Member id:  0000000000
```

16.9 Financial Transaction Page

The tables below provide a description of each field on the Financial Transaction page.

16.9.1 Non-Claim Specific Payouts to Providers

Table 19: Financial Transaction Page – Non-Claim Specific Payouts to Providers Field Descriptions

FIELD	DESCRIPTION
Transaction Number	The tracking number assigned to each financial transaction.
CCN	The cash control number (CCN) 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	The payment reason code.
Rendering Provider	The rendering provider of the 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.

16.9.2 Non-Claim Specific Refunds from Providers

Table 20: Financial Transaction Page – Non-Claim Specific Refunds from Providers Field Descriptions

FIELD	DESCRIPTION
CCN	The cash control tracking number assigned to refund checks for tracking purposes.
Refund Amount	The amount refunded by the 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.

16.9.3 Accounts Receivable

Table 21: Financial Transaction Page – Accounts Receivable Field Descriptions

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.
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 provider's account.

All initial accounts receivable allows 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.

Figure 20: Provider Remittance Advice Summary Report

REPORT: CRA-SUMM-R
RA#: 99999999

COMMONWEALTH OF KENTUCKY
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 01/08/2021
PAGE: 14

JD PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID	9999999999
NPI ID	9999999999
CHECK/EFT NUMBER	E99999999
ISSUE DATE	01/08/2021

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

	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TD NUMBER	MONTH-TD AMOUNT	YEAR-TD NUMBER	YEAR-TD AMOUNT
CLAIMS PAID	24	12,111.41	25	12,951.59	25	12,951.59
CLAIM ADJUSTMENTS	0	0.00	0	0.00	0	0.00
MASS ADJUSTMENTS	0	0.00	0	0.00	0	0.00
TOTAL CLAIM PAYMENTS	24	12,111.41	25	12,951.59	25	12,951.59
CLAIMS DENIED	1		1		1	
CLAIMS IN PROCESS	9					

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

PAYMENTS:			
CLAIMS PAYMENTS	12,111.41	12,951.59	12,951.59
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)	(0.00)
NON-CLAIM SPECIFIC OFFSETS	(0.00)	(0.00)	(0.00)
TOTAL CLAIM PAYMENTS	12,111.41	12,951.59	12,951.59
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	12,111.41	12,951.59	12,951.59

Figure 21: Provider Remittance Advice EOB Code Description Report

```
REPORT:  CRA-EOBM-R                    COMMONWEALTH OF KENTUCKY (M1)                    DATE:   12/11/2020
 RA#:     99999999                    MEDICAID MANAGEMENT INFORMATION SYSTEM           PAGE:         14
                                            PROVIDER REMITTANCE ADVICE
                                              EOB CODE DESCRIPTIONS


JD PROVIDER                                                                  PAYEE ID          9999999999
555 ANY STREET                                                               NPI ID
CITY, KY  55555-0000                                                         CHECK/EFT NUMBER  E999999999
                                                                            ISSUE DATE         12/11/2020


 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. DUPLICATE 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.
```

16.10 Summary Page

The tables below provide a description of each field on the Summary page:

Table 22: Summary Page Field Descriptions

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 Gainwell 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.

16.10.1 Payments

Table 23: Payments Field Descriptions

FIELD	DESCRIPTION
Claims Payment	The number of claims paid.
System Payouts	Any money owed to providers.
Net Payment	The total check amount.
Refunds	Any money refunded to Medicaid by a provider.
Other Financial	This field appears on the Summary page when appropriate.
Net Earnings	The 1099 amount.

Explanation of Benefits

Table 24: Explanation of Benefits Field Descriptions

FIELD	DESCRIPTION
EOB	A five-digit number denoting the explanation of benefits detailed on the Remittance Advice.
EOB Code Description	A description of the EOB code. All EOB codes detailed on the Remittance Advice are listed with a description/definition.
Count	The total number of times an EOB code is detailed on the Remittance Advice.

Explanation of Remarks

Table 25: Explanation of Remarks Field Descriptions

FIELD	DESCRIPTION
Remark	A five-digit number denoting the remark identified on the Remittance Advice.
Remark Code Description	A description of the Remark code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
Count	The total number of times a Remark code is detailed on the Remittance Advice.

Explanation of Adjustment Code

Table 26: Explanation of Adjustment Code Field Descriptions

FIELD	DESCRIPTION
Adjustment Code	A two-digit number denoting the reason for returning the claim.
Adjustment Code Description	A description of the Adjustment code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
Count	The total number of times an adjustment code is detailed on the Remittance Advice.

Explanation of RTP Codes

Table 27: Explanation of RTP Codes Field Descriptions

FIELD	DESCRIPTION
RTP Code	A two-digit number denoting the reason for returning the claim.
Return Code Description	A description of the RTP code. All RTP codes detailed on the Remittance Advice are listed with a description/definition.
Count	The total number of times an RTP code is detailed on the Remittance Advice.

17 Appendix G – 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:

Table 28: Remittance Advice Location Codes Field Descriptions

Code	Description
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	Gainwell On Hold
W	Hold Recoup – Further Review
X	Hold Recoup – Bankruptcy
Y	Hold Recoup – Appeal
Z	Hold Recoup – Resolution Hearing

18 Appendix H – 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:

Table 29: Remittance Advice Reason Code Field Descriptions

Code	Description	Code	Description
01	Prov Refund – Health Insur Paid	59	Non-Claim Related Overage
02	Prov Refund – Member/Rel Paid	60	Provider Initiated Adjustment
03	Prov Refund – Casualty Insu Paid	61	Provider Initiated CLM Credit
04	Prov Refund – Paid Wrong Vender	62	CLM CR – Paid Medicaid VS Xover
05	Prov Refund – Apply to Acct Recv	63	CLM CR – Paid Xover VS Medicaid
06	Prov Refund – Processing Error	64	CLM CR – Paid Inpatient VS Outp
07	Prov Refund – Billing Error	65	CLM CR – Paid Outpatient VS Inp
08	Prov Refund – Fraud	66	CLS Credit – Prov Number Changed
09	Prov Refund – Abuse	67	TPL CLM Not Found on History
10	Prov Refund – Duplicate Payment	68	FIN CLM Not Found on History
11	Prov Refund – Cost Settlement	69	Payout – Withhold Release
12	Prov Refund – Other/Unknown	71	Withhold – Encounter Data Unacceptable
13	Acct Receivable – Fraud	72	Overage .99 or Less
14	Acct Receivable – Abuse	73	No Medicaid/Partnership Enrollment
15	Acct Receivable – TPL	74	Withhold – Provider Data Unacceptable
16	Acct Recv – Cost Settlement	75	Withhold – PCP Data Unacceptable
17	Acct Receivable – Gainwell Request	76	Withhold – Other
18	Recoupment – Warrant Refund	77	A/R Member IPV
19	Act Receivable – SURS Other	78	CAP Adjustment – Other
20	Acct Receivable – Dup Payt	79	Member Not Eligible for DOS
21	Recoupment – Fraud	80	Adhoc Adjustment Request
22	Civil Money Penalty	81	Adj Due to System Corrections
23	Recoupment – Health Insur TPL	82	Converted Adjustment

Code	Description	Code	Description
24	Recoupment – Casualty Insur TPL	83	Mass Adj Warr Refund
25	Recoupment – Member Paid TPL	84	DMS Mass Adj Request
26	Recoupment – Processing Error	85	Mass Adj SURS Request
27	Recoupment – Billing Error	86	Third Party Paid – TPL
28	Recoupment – Cost Settlement	87	Claim Adjustment – TPL
29	Recoupment – Duplicate Payment	88	Beginning Dummy Recoupment Bal
30	Recoupment – Paid Wrong Vendor	89	Ending Dummy Recoupment Bal
31	Recoupment – SURS	90	Retro Rate Mass Adj
32	Payout – Advance to be Recouped	91	Beginning Credit Balance
33	Payout – Error on Refund	92	Ending Credit Balance
34	Payout – RTP	93	Beginning Dummy Credit Balance
35	Payout – Cost Settlement	94	Ending Dummy Credit Balance
36	Payout – Other	95	Beginning Recoupment Balance
37	Payout – Medicare Paid TPL	96	Ending Recoupment Balance
38	Recoupment – Medicare Paid TPL	97	Begin Dummy Rec Bal
39	Recoupment – DEDCO	98	End Dummy Recoup Balance
40	Provider Refund – Other TLP Rsn	99	Drug Unit Dose Adjustment
41	Acct Recv – Patient Assessment	AA	PCG 2 Part A Recoveries
42	Acct Recv – Orthodontic Fee	BB	PCG 2 Part B Recoveries
43	Acct Receivable – KENPAC	CB	PCG 2 AR CDR Hosp
44	Acct Recv – Other DMS Branch	DG	DRG Retro Review
45	Acct Receivable – Other	DR	Deceased Member Recoupment
46	Acct Receivable – CDR-HOSP-Audit	IP	Impact Plus
47	Act Rec – Demand Paymt Updt 1099	IR	Interest Payment
48	Act Rec – Demand Paymt No 1099	CC	Converted Claim Credit Balance
49	PCG	MS	Prog Intre Post Pay Rev Cont C
50	Recoupment – Cold Check	OR	On Demand Recoupment Refund
51	Recoupment – Program Integrity Post Payment Review Contractor A	RP	Recoupment Payout

Code	Description	Code	Description
52	Recoupment – Program Integrity Post Payment Review Contractor B	RR	Recoupment Refund
53	Claim Credit Balance	SC	SURS Contract
54	Recoupment – Other St Branch	SS	State Share Only
55	Recoupment – Other	UA	Gainwell Medicare Part A Recoup
56	Recoupment – TPL Contractor	UB	Gainwell Medicare Part B Recoup
57	Acct Recv – Advance Payment	XO	Reg. Psych. Crossover Refund
58	Recoupment – Advance Payment		

19 Appendix I – Remittance Advice Status Code (ST CD)

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

Table 30: Remittance Advice Status Code Field Descriptions

Code	Description
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	Gainwell On Hold
W	Hold Recoup – Further Review
X	Hold Recoup – Bankruptcy
Y	Hold Recoup – Appeal
Z	Hold Recoup – Resolution Hearing

20 Appendix J – Acronyms

The following acronyms are used in this document:

Table 31: Acronyms

Acronym	Description
A/R, AR	Accounts Receivable
AHF	Anti-Hemophilia Factor
BCCTP	Breast & Cervical Cancer Treatment Program
CAP	Corrective Action Plan
CCN	Cash Control Number
CCU	Central Control Unit
CDR	Claim Detail Requests
CLM	Claim
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CR	Credit
DCBS	Department for Community Based Services
DMS	Department for Medicaid Services
DOS	Date of Service
DRG	Diagnosis Related Group
ECS	Electronic Claims Submission
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOMB	Explanation of Medicare or Medicare Part C (Medicare Advantage) Benefits
EPA	Electronic Prior Authorization
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FDA	Food and Drug Administration
FFP	Federal Financial Participation
HIPAA	Health Insurance Portability and Accountability Act
HOSP	Hospital
ICD	International Classification of Diseases
ICF	Intermediate Care Facility

Acronym	Description
ICN	Internal Control Number
ICU	Intensive Care Unit
ID	Identification
IRF	Inpatient Rehabilitation Facility
KCHIP	Kentucky Children's Health Insurance Program
KY	Kentucky
LTCH	Long-Term Care Hospital
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NDC	National Drug Code
NPI	National Provider Identifier
OCR	Optical Character Recognition
PCP	Primary Care Provider
PE	Presumptive Eligibility
POA	Present on Admission
PRO	Peer Review Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RTP	Return to Provider
SLMB	Specified Low-Income Medicare Beneficiaries
SNF	Skilled Nursing Facility
SURS	Surveillance and Utilization Review Subsystem
TOB	Type of Bill
TPL	Third Party Liability
UB	Uniform Billing
UPIN	Unique Physician Identification Number
VREV	Voice Response Eligibility Verification