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CABINET FOR HEALTH  
AND FAMILY SERVICES

**Commonwealth of Kentucky  
KY Medicaid**

**Provider Billing Instructions  
for  
School Based Health Services  
Provider Type – 21**

Version 6.8  
December 13, 2023

## Document Change Log

| Version | Date       | Name             | Comments                                                                                                                                                                   |
|---------|------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.0     | 10/24/2005 | EDS              | Initial creation of DRAFT School Based Health Services Provider Type – 21.                                                                                                 |
| 1.1     | 12/20/2005 | EDS              | Update with revisions made by DMS.                                                                                                                                         |
| 1.2     | 01/19/2006 | EDS              | Update with new Provider Rep listing.                                                                                                                                      |
| 1.3     | 02/13/2006 | Carolyn Stearman | Updated with revisions requested by DMS.                                                                                                                                   |
| 1.4     | 04/14/2006 | Lize Deane       | Updated with revisions requested by Commonwealth.                                                                                                                          |
| 1.5     | 04/27/2006 | Lize Deane       | Updated with revisions requested by Commonwealth.<br><i>v1.4 – 1.5 are actually the same as revisions were made back-to-back and no publication would have been made.</i>  |
| 1.6     | 06/07/2006 | Tammy Delk       | Updated with revisions requested by Commonwealth. (Comment Log created)                                                                                                    |
| 1.7     | 08/18/2006 | Ann Murray       | Updated with revisions submitted by Stayce Towles.                                                                                                                         |
| 1.8     | 08/25/2006 | Ann Murray       | Updated with revisions submitted by Brenda Orberson.                                                                                                                       |
| 1.9     | 08/30/2006 | Ann Murray       | Updated with revisions submitted by Stayce Towles.                                                                                                                         |
| 2.0     | 08/31/2006 | Ann Murray       | Updated with revisions submitted by Stayce Towles.<br><i>v1.7 – 2.0 are actually the same as revisions were made back-to-back and no publication would have been made.</i> |
| 2.1     | 9/15/2006  | Cathy Hill       | Updated with revisions submitted by Vicky Hicks.                                                                                                                           |
| 2.2     | 09/18/2006 | Ann Murray       | Replaced Provider Representative table.<br><i>v2.1 – 2.2 are actually the same as revisions were made back-to-back and no publication would have been made.</i>            |
| 2.3     | 01/02/2007 | Ann Murray       | Updated with revisions requested by Stayce Towles.                                                                                                                         |
| 2.4     | 01/30/2007 | Ann Murray       | Updated with revisions requested during walkthrough.                                                                                                                       |

| Version | Date       | Name                         | Comments                                                                                                                                                                                     |
|---------|------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2.5     | 02/15/2007 | Ann Murray                   | Updated Appendix B, KY Medicaid card and ICN.                                                                                                                                                |
| 2.6     | 02/21/2007 | Ann Murray                   | Replaced Provider Rep table.                                                                                                                                                                 |
| 2.7     | 02/23/2007 | Ann Murray                   | Revised according comment log Walkthrough.<br>v2.3 – 2.7 are actually the same as revisions were made back-to-back and no publication would have been made.                                  |
| 2.8     | 04/30/2007 | Ann Murray                   | Updated and added claim forms and descriptors.                                                                                                                                               |
| 2.9     | 01/31/2008 | Ann Murray                   | Added FL 32.                                                                                                                                                                                 |
| 3.0     | 05/19/2008 | Cathy Hill                   | Inserted revised provider rep list and presumptive eligibility per Stayce Towles.                                                                                                            |
| 3.1     | 05/20/2008 | Cathy Hill                   | Made revisions specified by Stayce Towles.                                                                                                                                                   |
| 3.2     | 03/09/2009 | Cathy Hill                   | Made changes from KYHealth Choices to KY Medicaid per Stayce Towles.                                                                                                                         |
| 3.3     | 03/11/2009 | Cathy Hill                   | Revised contact info from First Health to Dept for Medicaid Services per Stayce Towles.                                                                                                      |
| 3.4     | 03/30/2009 | Ann Murray                   | Made global revisions per DMS request.<br>v3.2 – 3.4 are actually the same as revisions were made back-to-back and no publication would have been made.                                      |
| 3.5     | 06/10/2009 | Cathy Hill                   | Deleted references to Procedure Code 90887, per Patti George; corrected a typo.                                                                                                              |
| 3.6     | 09/08/2009 | Ann Murray                   | Replaced Provider Rep list.                                                                                                                                                                  |
| 3.7     | 10/21/2009 | Ron Chandler                 | Replaced all instances of “EDS” with “HP”.                                                                                                                                                   |
| 3.8     | 11/10/2009 | Ann Murray                   | Replaced all instances of @eds.com with @hp.com. Removed the HIPAA section.<br>v3.7 – 3.8 are actually the same as revisions were made back-to-back and no publication would have been made. |
| 3.9     | 3/8/2010   | Ron Chandler                 | Inserted new provider rep list.                                                                                                                                                              |
| 4.0     | 11/15/2010 | Patti George<br>Ron Chandler | Updated CMS 1500 claim form example patient birthdate year to read “01” instead of “42”.                                                                                                     |
| 4.1     | 01/18/2011 | Ann Murray                   | Updated global sections.                                                                                                                                                                     |
| 4.2     | 11/29/2011 | Brenda Orberon<br>Ann Murray | Updated 5010 changes.<br>DMS approved 12/27/2011, Renee Thomas.                                                                                                                              |

| Version | Date       | Name                          | Comments                                                                                                                                                                         |
|---------|------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4.3     | 02/08/2012 | Stayce Towles<br>Ann Murray   | Updated provider rep listing.<br>DMS Approved 02/14/2012, John Hoffman.                                                                                                          |
| 4.4     | 02/21/2012 | Brenda Orberon<br>Ann Murray  | Updated due to typing error.                                                                                                                                                     |
| 4.5     | 02/22/2012 | Brenda Orberon<br>Ann Murray  | Global updates made to remove all references to KenPAC and Lockin.<br>DMS Approved 03/09/2012, John Hoffman.                                                                     |
| 4.6     | 04/05/2012 | Stayce Towles<br>Ann Murray   | Updated provider rep listing.<br>DMS Approved 04/11/2012, John Hoffman.                                                                                                          |
| 4.7     | 08/15/2012 | Stayce Towles<br>Patti George | Section 6 - Change Taxonomy Qualifier from PXC to ZZ in form locators 24I and 33B per CO18459.<br><i>(Update of Provider Inquiry form approved by John Hoffman on 08/30/12.)</i> |
| 4.8     | 01/22/2013 | Vicky Hicks<br>Patti George   | Update section 1.2.2.2 to reflect former Passport Members having a choice of MCOs as of 1/1/2013.<br>DMS Approved 02/27/2013, John Hoffman.                                      |
| 4.9     | 06/03/2013 | Vicky Hicks<br>Patti George   | Updates to NET PAYMENT and NET EARNINGS descriptions in Section 8.10.1.<br>DMS Approved 07/09/2013, John Hoffman.                                                                |
| 4.10    | 07/30/2013 | Stayce Towles<br>Patti George | Update to section 5.10 - Provider Rep listing.                                                                                                                                   |
| 5.0     | 12/04/2013 | Vicky Hicks<br>Stayce Towles  | Update to section 6 - add CMS form (02/12) and detailed instructions.<br>DMS approved 12/12/2013, John Hoffmann.                                                                 |
| 5.1     | 03/24/2014 | Stayce Towles                 | Updated sections 1 - 5 per DMS and removed CMS 1500 (08/05). Approved 4-7-14 by Lee Guice.                                                                                       |
| 5.2     | 07/07/2015 | Stayce Towles                 | Updated detailed instructions for field 21 – diagnosis indicator. Approved by John Hoffmann, OATS, 7/6/15.                                                                       |
| 5.3     | 07/15/2015 | Stayce Towles                 | Updated place of service codes per CO 24859.<br>Also, updated procedure code list per DMS, Lucy Senters. Lucy approved on August 4, 2015.                                        |

| Version | Date       | Name                       | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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| 5.4     | 08/10/2015 | Stayce Towles              | Updated the procedure code list with codes that exclude modifiers, per DMS, Lucy Senters. Approved 8/10/2015.                                                                                                                                                                                                                                                                                                                                                                                                  |
| 5.5     | 08/17/2015 | Stayce Towles              | Update procedure code description 96150<br>Change to: health and behavior evaluation each 15 minutes, per Lucy Senters, DMS.<br>Lucy Senters, DMS approved on August 18, 2015.                                                                                                                                                                                                                                                                                                                                 |
| 5.6     | 06/17/2017 | Vicky Hicks                | Added Place of Service 19 per CO26401, updated rep list.<br>Approved by Charles Douglass, DMS, 6/6/2016.                                                                                                                                                                                                                                                                                                                                                                                                       |
| 5.7     | 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 <a href="http://www.kymmis.com">www.kymmis.com</a> under Companion Guides and EDI Guides."<br>Approved by Charles Douglass, DMS, 2/1/17.<br>Added information for form locators 17 and 17B regarding Referring and Ordering Providers.<br>Approved by Charles Douglass, DMS, 2/8/2017. |
| 5.8     | 01/03/2019 | Vicky Hicks                | Updated Provider Inquiry Form, replaced all instances of HP with DXC Technology, updated Rep List.                                                                                                                                                                                                                                                                                                                                                                                                             |
| 5.9     | 05/14/2019 | Vicky Hicks<br>Mary Larson | Updated: 1) Provider Rep Table, 2) all forms, 3) DMS URLs in Introduction, 4) ICD-9/ICD-9-CM to ICD-10, 5) added Place of Service code 02 – Telehealth per CO29475.                                                                                                                                                                                                                                                                                                                                            |
| 5.9     | 12/20/2019 | Vicky Hicks                | Corrected page 65 modifier HP on the School Psychologist Doctoral Level due to typographical error.                                                                                                                                                                                                                                                                                                                                                                                                            |
| 6.0     | 03/25/2020 | Vicky Hicks                | Added information regarding Free Care per CO30517.                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 6.1     | 07/17/2020 | Vicky Hicks<br>Mary Larson | Updated Provider Representative List extensions.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 6.2     | 12/22/2020 | Vicky Hicks<br>Mary Larson | Updated the Cash Refund Documentation form. Form approved 03/06/2020 by John Hay, DMS.<br>Updated <i>DXC Technology</i> to <i>Gainwell Technologies</i> or <i>Gainwell</i> , including all forms.                                                                                                                                                                                                                                                                                                              |

| Version | Date       | Name                       | Comments                                                                                                                                                                                                                          |
|---------|------------|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6.3     | 02/15/2021 | Vicky Hicks<br>Mary Larson | Edited the entire document for grammar, updated tables and reports, converted some lists to tables, added an acronym list as an Appendix.                                                                                         |
| 6.4     | 10/27/2021 | Vicky Hicks<br>Mary Larson | Changed the logo on the title page and swipe card graphic per CO 33032. DMS approved 10/14/2021.<br><br>Updated the Provider Representative List.                                                                                 |
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| 6.6     | 10/18/2022 | Mary Larson                | Updated logo on title page.                                                                                                                                                                                                       |
| 6.7     | 03/03/2023 | Vicky Hicks<br>Mary Larson | Inserted a new Return to Provider letter.                                                                                                                                                                                         |
| 6.8     | 12/13/2023 | Vicky Hicks<br>Mary Larson | Updated 6.2.1 Detailed Instructions, Field 24D shaded and non-shaded areas; added page: <i>Community Health Workers Certification Needs</i> ; added <i>CHW</i> to acronym list. Updates added per CO 34688.                       |

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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](http://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>

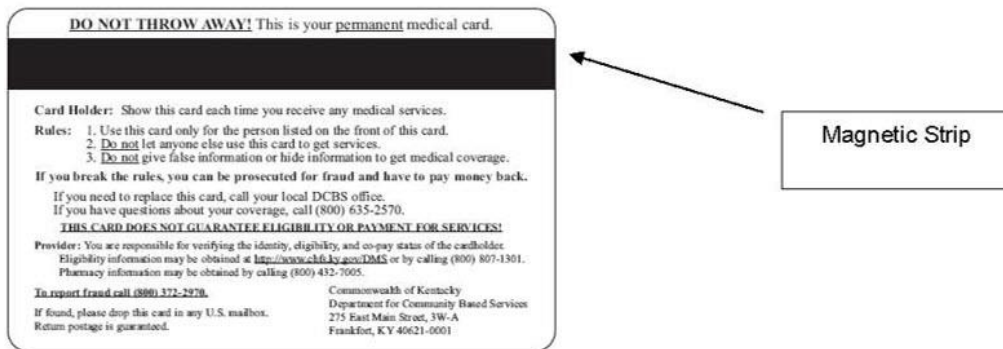
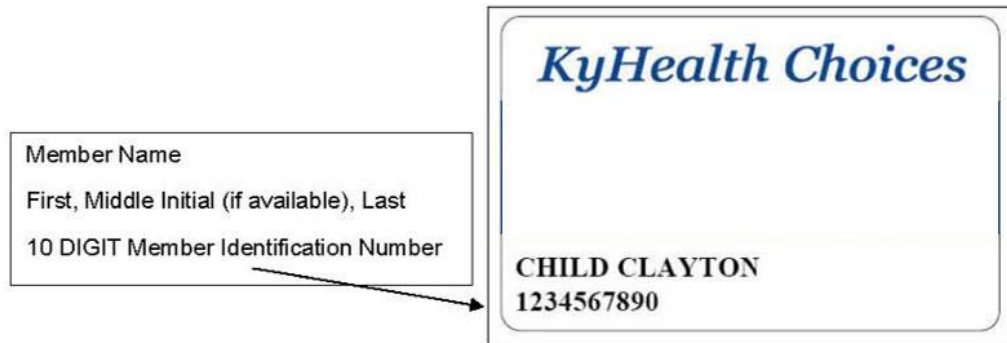
## 1.2 Member Eligibility

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

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

**Note: Payment cannot be made for services provided to ineligible members. Possession of a member identification card does not guarantee payment for all medical services.**

### 1.2.1 Plastic Swipe KY Medicaid Card



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

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## 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
- Anthem Blue Cross Blue Shield at 1-800-880-2583
- 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

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#### 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 EDH\\_Helpdesk@dx.com](mailto:KY_EDH_Helpdesk@dx.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 40602-2100  
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%20Relations/KYHealthNetManuals.aspx>

## **4 General Billing Instructions for Paper Claim Forms**

### **4.1 General Instructions**

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

### **4.2 Imaging**

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

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

- USE BLACK INK ONLY
- Do not use glue
- Do not use more than one staple per claim
- Press hard to guarantee strong print density if 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 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 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

### 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)

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 TPL 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>

**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

Access the KY HealthNet website to obtain blank Prior Authorization forms:

<http://www.kymmis.com/kymmis/Provider%20Relations/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 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

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.

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

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

\_\_\_\_\_

\_\_\_\_\_

12. Please specify the REASON for the adjustment or 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

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/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



**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](http://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

| Martha Edwards<br>Martha.Senn@gainwelltechnologies.com |            |            | Vicky Hicks<br>Vicky.Hicks@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       | DAVISS                                              | LEE       | SCOTT      |
| CRITTENDEN                                             | LIVINGSTON | TRIGG      | ELLIOTT                                             | LEWIS     | SHELBY     |
| CUMBERLAND                                             | LOGAN      | UNION      | ESTILL                                              | MADISON   | SPENCER    |
| EDMONSON                                               | LYON       | WARREN     | FAYETTE                                             | MAGOFFIN  | TRIMBLE    |
| FLOYD                                                  | MARION     | WAYNE      | FLEMING                                             | MARTIN    | WASHINGTON |
| FULTON                                                 | MARSHALL   | WEBSTER    | FRANKLIN                                            | MASON     | WOLFE      |
| GRAVES                                                 | MCCRACKEN  | WHITLEY    | GALLATIN                                            | MEADE     | WOODFORD   |

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

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



## 6 Completion of CMS-1500 Paper Claim Form

The CMS-1500 claim form is used to bill services for School Based Health Services Care. A copy of a claim form is shown on the following page.

Providers may order CMS-1500 claim forms from the:

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

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

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



**HEALTH INSURANCE CLAIM FORM**

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----|---------------------------|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|-----|---|--|--|--|--|--|--|--|--|--|--|-----|---|--|--|--|--|--|--|--|--|--|--|-----|---|--|--|--|--|--|--|--|--|--|--|-----|---|--|--|--|--|--|--|--|--|--|--|-----|
| PICA <span style="float: right;">PICA</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (DA/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA (BLU/LUNG) <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 3. PATIENT'S BIRTH DATE MM DO YY SEX M <input type="checkbox"/> F <input type="checkbox"/>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                               |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)                                                                                                                                                                                                                                                                                                                |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 5. PATIENT'S ADDRESS (No., Street)<br>CITY STATE ZIP CODE TELEPHONE (include Area Code) ( )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>                                                                                                                                                                                                 |  |                                                                                                                                                                               |  | 7. INSURED'S ADDRESS (No., Street)<br>CITY STATE ZIP CODE TELEPHONE (include Area Code) ( )                                                                                                                                                                                                                                                                              |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/><br>b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____<br>c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/><br>10d. CLAIM CODES (Designated by NUCC) |  |                                                                                                                                                                               |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>a. INSURED'S DATE OF BIRTH MM DO YY SEX M <input type="checkbox"/> F <input type="checkbox"/><br>b. OTHER CLAIM ID (Designated by NUCC)<br>c. INSURANCE PLAN NAME OR PROGRAM NAME<br>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d. |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br>SIGNED _____ DATE _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNED _____ |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DO YY QUAL _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 15. OTHER DATE MM DO YY QUAL _____                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                               |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DO YY TO MM DO YY                                                                                                                                                                                                                                                                                         |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 17a. _____<br>17b. NPI _____                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                               |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DO YY TO MM DO YY                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <input type="checkbox"/><br>A. _____ B. _____ C. _____ D. _____<br>E. _____ F. _____ G. _____ H. _____<br>I. _____ J. _____ K. _____ L. _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____<br>23. PRIOR AUTHORIZATION NUMBER _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 24. A. DATE(S) OF SERVICE From MM DO YY To MM DO YY B. PLACE OF SERVICE C. EMO D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. XPCS/ Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">1</td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> </table> |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     | 1                         |  |  |  |  |  |  |  |  |  |  |  | 2 |  |  |  |  |  |  |  |  |  |  | NPI | 3 |  |  |  |  |  |  |  |  |  |  | NPI | 4 |  |  |  |  |  |  |  |  |  |  | NPI | 5 |  |  |  |  |  |  |  |  |  |  | NPI | 6 |  |  |  |  |  |  |  |  |  |  | NPI |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  | NPI |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  | NPI |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  | NPI |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  | NPI |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  | NPI |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 26. PATIENT'S ACCOUNT NO.                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                               |  | 27. ACCEPT ASSIGNMENT? (For gmt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                              |  |  |     | 28. TOTAL CHARGE \$ _____ |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 29. AMOUNT PAID \$ _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 30. Rsvd for NUCC Use                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                               |  | 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)<br>SIGNED _____ DATE _____                                                                                                                                                                        |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |
| 32. SERVICE FACILITY LOCATION INFORMATION<br>a. _____ b. _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 33. BILLING PROVIDER INFO & PH # ( )<br>a. _____ b. _____                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                          |  |  |     |                           |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |   |  |  |  |  |  |  |  |  |  |  |     |

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

PLEASE PRINT OR TYPE

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

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

### 6.2.1 Detailed Instructions

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

The following fields must be completed:

| FIELD NUMBER | FIELD NAME AND DESCRIPTION                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1A           | <p><b>Insured's I.D. Number</b></p> <p>Enter the 10-digit member identification number exactly as it appears on the current member identification card.</p>                                                                                                                                                                                                                                                                                                                       |
| 2            | <p><b>Patient's Name</b></p> <p>Enter the member's last name, first name, and middle initial exactly as it appears on the member identification card.</p>                                                                                                                                                                                                                                                                                                                         |
| 3            | <p><b>Date of Birth</b></p> <p>Enter the date of birth for the member.</p>                                                                                                                                                                                                                                                                                                                                                                                                        |
| 9            | <p><b>Other Insured's Name</b></p> <p>Enter the Insured's Name. This is required only if the member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim.</p>                                                                                                                                                                                                                                                          |
| 9A           | <p><b>Other Insured's Policy Group Number</b></p> <p>This is required only if the member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. If this field is completed, also complete fields 9D and 29.</p> <p><b>Note:</b> If other insurance denies the submitted claim, leave Fields 9, 9A, 9D, and 29 blank and attach the denial statement from the other insurance carrier to the CMS-1500 (02/12) claim.</p> |
| 9D           | <p><b>Insurance Plan or Program Name</b></p> <p>Enter the member's insurance carrier name, but only if there is an entry in 9.</p>                                                                                                                                                                                                                                                                                                                                                |
| 10           | <p><b>Patient's Condition</b></p> <p>This is required if the member's condition is related to employment, auto accident, or other accident. Check the appropriate block if the member's condition relates to any of the above.</p>                                                                                                                                                                                                                                                |
| 17           | <p><b>Name of Referring Provider or Other Source</b></p> <p>Enter the qualifier and the name of the Referring Provider or Ordering Provider, if applicable.</p> <p><b>Qualifiers:</b></p> <p>DN – denotes Referring Provider</p> <p>DK – denotes Ordering Provider</p>                                                                                                                                                                                                            |

| FIELD NUMBER | FIELD NAME AND DESCRIPTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 17B          | <p><b>Name of Referring Provider or Other Source</b></p> <p>Enter the Referring or Ordering Provider National Provider Identifier (NPI), if applicable.</p>                                                                                                                                                                                                                                                                                                                                                                                                               |
| 21           | <p><b>Diagnosis or Nature of Illness or Injury</b></p> <p>Enter an ICD indicator in the upper right corner to indicate the type of diagnosis being used.</p> <p>9 = ICD-9</p> <p>0 = ICD-10</p> <p>Twelve diagnosis codes may be entered.</p>                                                                                                                                                                                                                                                                                                                             |
| 23           | <p><b>Prior Authorization Number</b></p> <p>Enter the PA number assigned for these procedures or to identify a school-based service as "Free Care" enter FREECARE99.</p>                                                                                                                                                                                                                                                                                                                                                                                                  |
| 24A          | <p><b>Date of Service (Non-Shaded Area)</b></p> <p>Enter the date in month, day, year format (MMDDYY).</p> <p><b>Note:</b> Do not span date this field. Each line item must reflect a single date of service.</p>                                                                                                                                                                                                                                                                                                                                                         |
| 24B          | <p><b>Place of Service (Non-Shaded Area)</b></p> <p>Enter the appropriate two-digit place of service code which identifies the location where services were rendered.</p> <p><b>Note:</b> Reference the Place of Service appendix for valid codes.</p>                                                                                                                                                                                                                                                                                                                    |
| 24C          | <p><b>EMG (Shaded Area)</b></p> <p>Enter the number of students in the group when billing for group procedures. A valid entry is 1 – 6.</p>                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 24D          | <p><b>Procedure Code (Non-Shaded Area)</b></p> <p>Enter the appropriate HIPAA compliant five-digit procedure code.</p> <p><b>Note:</b> Community Health Worker (CHW) services may be billed using procedure codes 98960, 98961, or 98962 if applicable, and in conjunction with the UB modifier. This change is effective with dates of service 07/01/2023 and after.</p>                                                                                                                                                                                                 |
|              | <p><b>Modifier (Non-Shaded Area)</b></p> <p>Enter the appropriate two-digit modifier, if applicable.</p> <p>Modifier 25 should be used only with an evaluation and management (E&amp;M) service code and only when a significant, separately identifiable evaluation and management service is provided by the same provider to the same patient on the same day of the procedure or service. Documentation is not required to be submitted with the claim, but appropriate documentation for the procedure and evaluation and management service must be maintained.</p> |
|              | <p><b>Modifier (Shaded Area)</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

| FIELD NUMBER | FIELD NAME AND DESCRIPTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |    |                                                                                   |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----------------------------------------------------------------------------------|
|              | <p>Enter "EI" for Employee Identifier followed by the three-digit employee ID number assigned by the school.</p> <p><b>Note:</b> See Appendix F Procedural Coding for School Based Health Services for a list of valid procedure codes and modifiers.</p> <p><b>Modifier (Shaded Area)</b></p> <table border="1" data-bbox="375 495 1412 583"> <tr> <td data-bbox="375 495 500 583">UB</td> <td data-bbox="500 495 1412 583">For services rendered by a Community Health Worker, the modifier UB must be used.</td> </tr> </table> | UB | For services rendered by a Community Health Worker, the modifier UB must be used. |
| UB           | For services rendered by a Community Health Worker, the modifier UB must be used.                                                                                                                                                                                                                                                                                                                                                                                                                                                  |    |                                                                                   |
| 24E          | <p><b>Diagnosis Code Indicator (Non-Shaded Area)</b></p> <p>Enter the diagnosis <i>pointers</i> A – L to refer to a diagnosis code in field 21. Do not enter the actual ICD-10 diagnosis code.</p>                                                                                                                                                                                                                                                                                                                                 |    |                                                                                   |
| 24F          | <p><b>Charges (Non-Shaded Area)</b></p> <p>Enter the usual and customary charge for the service being provided to the member.</p>                                                                                                                                                                                                                                                                                                                                                                                                  |    |                                                                                   |
| 24G          | <p><b>Days or Units (Non-Shaded Area)</b></p> <p>Enter the number of days or units of service provided for the member on this date of service.</p>                                                                                                                                                                                                                                                                                                                                                                                 |    |                                                                                   |
| 24I          | <p><b>ID Qualifier (Shaded Area)</b></p> <p>Enter a ZZ to indicate Taxonomy.</p> <p><b>Note:</b> Those KY Medicaid providers who have a one-to-one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</p>                                                                                                                              |    |                                                                                   |
| 24J          | <p><b>Rendering Provider ID # (Shaded Area)</b></p> <p>Enter the Taxonomy number.</p> <p><b>Note:</b> Those KY Medicaid providers who have a one-to-one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</p> <p><b>(Non-Shaded Area)</b></p> <p>Enter the appropriate NPI number.</p>                                                |    |                                                                                   |
| 26           | <p><b>Patient Account No.</b></p> <p>Enter the patient account number, if desired. Gainwell types the first 14 or fewer digits. This number appears on the remittance statement as the invoice number.</p>                                                                                                                                                                                                                                                                                                                         |    |                                                                                   |
| 28           | <p><b>Total Charges</b></p> <p>Enter the total of all individual charges entered in Field 24F. Total each claim separately.</p>                                                                                                                                                                                                                                                                                                                                                                                                    |    |                                                                                   |

| FIELD NUMBER | FIELD NAME AND DESCRIPTION                                                                                                                                                                                                                                                                                                                                                                 |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 29           | <p><b>Amount Paid</b><br/>Enter any payment from an insurance company, IF NO PAYMENT, LEAVE BLANK.</p>                                                                                                                                                                                                                                                                                     |
| 31           | <p><b>Date</b><br/>Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.</p>                                                                                                                                                                                                                                                       |
| 32           | <p><b>Service Facility Location Information</b><br/>If the address in Form Locator 33 is not the address of where the service was rendered, Form Locator 32 must be completed.</p>                                                                                                                                                                                                         |
| 33           | <p><b>Physician/Supplier's Billing Name, Address, Zip Code, and Phone Number</b><br/>Enter the provider's name, address, zip code, and phone number.</p>                                                                                                                                                                                                                                   |
| 33A          | <p><b>NPI</b><br/>Enter the appropriate NPI number.</p>                                                                                                                                                                                                                                                                                                                                    |
| 33B          | <p><b>(Shaded Area)</b><br/>Enter ZZ and the Pay To Taxonomy number.<br/><b>Note:</b> Those KY Medicaid providers who have a one-to-one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</p> |

### **6.3 Community Health Workers Certification Needs**

Providers are to keep Community Health Workers (CHW) certifications on file for random audits to ensure compliance.

Community Health Workers must complete a competency-based community health worker training program offered by an organization approved by the Kentucky Department for Public Health.

**OR** shall be certified by the Kentucky Department for Public Health.

Certifications and additional information may be found at the following link:

<https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/chwp.aspx>

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

The following hints are helpful when filing:

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

## 6.5 Mailing Information

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

Mail completed claims to:

Gainwell Technologies  
P.O. Box 2101  
Frankfort, KY 40602-2101



## 7 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:

**11 – 20 – 032 – 123456**

---

**1            2            3            4**

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:

| 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

## 8 Appendix B – Remittance Advice

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

### 8.1 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:

| 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.<br><b>Note:</b> 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.

## 8.2 Title

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

|                    |                                        |                  |
|--------------------|----------------------------------------|------------------|
| REPORT: CRA-XBPD-R | COMMONWEALTH OF KENTUCKY               | DATE: 01/08/2021 |
| RA#: 99999999      | MEDICAID MANAGEMENT INFORMATION SYSTEM | PAGE: 2          |
|                    | PROVIDER REMITTANCE ADVICE             |                  |

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

## 8.3 Banner Page

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

REPORT: CRA-BANN-R  
RA#: 99999999

COMMONWEALTH OF KENTUCKY  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
PROVIDER BANNER MESSAGE

DATE: 01/08/2021  
PAGE: 1

JD PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 9999999999  
NPI ID 9999999999  
CHECK/EFT NUMBER E999999999  
ISSUE DATE 01/08/2021

REPORT: CRA-PRPD-R  
 RA#: 99999999

COMMONWEALTH OF KENTUCKY  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE ADVICE  
 CMS 1500 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 E999999999  
 ISSUE DATE 01/08/2021

\*\*\*\* RENDERING PROVIDER NAME: JD PROVIDER

\*\*\*\* RENDERING PROVIDER 9999999999 \*\*\*\* MEMBER OF CLINIC 999999999 \*\*\*\*

| --ICN--               | SERVICE DATES | BILLED                 | ALLOWED | TPL    | SPENDDOWN | CO-PAY | PAID   |
|-----------------------|---------------|------------------------|---------|--------|-----------|--------|--------|
| --PATIENT NUMBER--    | FROM THRU     | AMOUNT                 | AMOUNT  | AMOUNT | AMOUNT    | AMOUNT | AMOUNT |
| MEMBER NAME: JOHN DOE |               | MEMBER ID.: 9999999999 |         |        |           |        |        |
| 999999999999          | 123120 123120 | 5,000.00               |         | 0.00   |           | 0.00   |        |
| 9999999999-9999999999 |               |                        | 969.32  |        | 0.00      |        | 969.32 |

| LN                          | PL | SERV | PROC  | CD | MODIFIERS | UNITS | SERVICE DATES | RENDERING  | BILLED   | ALLOWED | DETAIL | EOBS |        |
|-----------------------------|----|------|-------|----|-----------|-------|---------------|------------|----------|---------|--------|------|--------|
|                             |    |      |       |    |           |       | FROM THRU     | PROVIDER   | AMOUNT   | AMOUNT  |        |      |        |
| 0001                        | 11 |      | 78815 | TC |           | 1.00  | 123120 123120 | 9999999999 | 5,000.00 | 962.32  | 3001   | 9918 |        |
| NDC:                        |    |      |       |    |           |       |               |            |          |         |        |      |        |
| Total:                      |    |      |       |    |           | 1.00  |               |            | 5,000.00 | 962.32  |        |      |        |
| TOTAL CMS 1500 CLAIMS PAID: |    |      |       |    |           | 1     |               |            | 5,000.00 | 969.32  | 0.00   | 0.00 | 969.32 |

## 8.4 Paid Claims Page

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

| <b>FIELD</b>                    | <b>DESCRIPTION</b>                                                                                                                                     |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| PATIENT ACCOUNT                 | The 14-digit alpha/numeric Patient Account Number from Form Locator 3.                                                                                 |
| MEMBER NAME                     | The member's last name and first initial.                                                                                                              |
| MEMBER NUMBER                   | The member's ten-digit identification number as it appears on the member's identification card.                                                        |
| ICN                             | The 12-digit unique system-generated identification number assigned to each claim by 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 allowed amount for Medicaid.                                                                                                                       |
| TPL AMOUNT                      | Amount paid, if any, by private insurance (excluding Medicaid and Medicare).                                                                           |
| SPENDDOWN AMOUNT                | The amount collected from the member.                                                                                                                  |
| COPAY AMOUNT                    | The amount collected from the member.                                                                                                                  |
| PAID AMOUNT                     | The total dollar amount reimbursed by Medicaid for the claim listed.                                                                                   |
| EOB                             | Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.      |
| CLAIMS PAID ON THIS RA          | The total number of paid claims on the Remittance Advice.                                                                                              |
| TOTAL BILLED                    | The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section). |
| TOTAL PAID                      | The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).       |

REPORT: CRA-PRDN-R  
 RA#: 99999999

COMMONWEALTH OF KENTUCKY  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE ADVICE  
 CMS 1500 CLAIMS DENIED

DATE: 01/08/2021  
 PAGE: 3

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

PAYEE ID 9999999999  
 NPI ID 9999999999  
 CHECK/EFT NUMBER E999999999  
 ISSUE DATE 01/08/2021

\*\*\*\* RENDERING PROVIDER NAME: JD PROVIDER

\*\*\*\* RENDERING PROVIDER 9999999999 \*\*\*\* MEMBER OF CLINIC 999999999 \*\*\*\*

| ICN                   | PATIENT NUMBER | SERVICE DATES | BILLED AMOUNT          | TPL AMOUNT | SPENDDOWN AMOUNT |
|-----------------------|----------------|---------------|------------------------|------------|------------------|
| MEMBER NAME: JOHN DOE |                |               | MEMBER ID.: 9999999999 |            |                  |
| 99999999999999        |                | 030120 030120 | 5,000.00               | 1,008.92   | 0.00             |
| 9999999999-9999999999 |                |               |                        |            |                  |

HEADER EOBS: 1015 9003

| LN                               | PL | SERV | PROC  | CD | MODIFIERS | UNITS | SERVICE DATES | RENDERING PROVIDER | BILLED AMOUNT | DETAIL EOBS |
|----------------------------------|----|------|-------|----|-----------|-------|---------------|--------------------|---------------|-------------|
| 0001                             | 11 |      | 78815 | TC | PS        | 1.00  | 030120 030120 | 9999999999         | 5,000.00      |             |
| NDC:                             |    |      |       |    |           |       |               |                    |               |             |
| Total:                           |    |      |       |    |           | 1.00  |               |                    | 5,000.00      |             |
| TOTAL NET EFFECT OF CLAIMS PAID: |    |      |       |    |           | 1     |               |                    | 5,000.00      |             |

## 8.5 Denied Claims Page

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

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



REPORT: CRA-PRSU-R  
 RA#: 99999999

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

DATE: 01/01/2021  
 PAGE: 2

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

PAYEE ID 999999999  
 NPI ID 999999999  
 CHECK/EFT NUMBER E99999999  
 ISSUE DATE 01/01/2021

\*\*\*\* RENDERING PROVIDER NAME: JD PROVIDER

\*\*\*\* RENDERING PROVIDER 9999999999 \*\*\*\* MEMBER OF CLINIC 999999999 \*\*\*\*

| ICN                   | PATIENT NUMBER | SERVICE DATES | BILLED AMOUNT          | TPL AMOUNT |
|-----------------------|----------------|---------------|------------------------|------------|
| MEMBER NAME: JOHN DOE |                |               | MEMBER ID.: 9999999999 |            |
| 99999999999999        |                | 031020 031020 | 5,000.00               | 1,008.92   |
| 999999999-9999999999  |                |               |                        |            |

HEADER EOBS: 9003 1752

| LN                                     | PL | SERV  | PROC | CD | MODIFIERS | UNITS | SERVICE DATES | RENDERING PROVIDER | BILLED AMOUNT | DETAIL EOBS |      |
|----------------------------------------|----|-------|------|----|-----------|-------|---------------|--------------------|---------------|-------------|------|
| 0001                                   | 11 | 78815 | TC   | PS |           | 1.00  | 030120 030120 | 9999999999         | 5,000.00      |             |      |
| NDC:                                   |    |       |      |    |           |       |               |                    |               |             |      |
| Total:                                 |    |       |      |    |           | 1.00  |               |                    | 5,000.00      |             |      |
| TOTAL NET EFFECT OF CLAIMS IN PROCESS: |    |       |      |    |           |       | 1             |                    | 5,000.00      | 1,008.92    | 0.00 |

## 8.6 Claims in Process Page

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

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

REPORT: CRA-IPPD-R  
RA#: 99999999

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

DATE: 01/08/2021  
PAGE: 2

JD PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 999999999  
NPI ID  
CHECK/EFT NUMBER E99999999  
ISSUE DATE 01/08/2021

-ICN-- REASON CODE  
999999999999 01

CLAIMS RETURNED: 01

## 8.7 Returned Claim

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

| 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.



## 8.8 Adjusted Claims Page

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

| FIELD                           | DESCRIPTION                                                                                                                                       |
|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| PATIENT ACCOUNT                 | The 14-digit alpha/numeric Patient Control Number from Form Locator 3.                                                                            |
| MEMBER NAME                     | The member's last name and first initial.                                                                                                         |
| MEMBER NUMBER                   | The member's ten-digit identification number as it appears on the member's identification card.                                                   |
| ICN                             | The 12-digit unique system-generated identification number assigned to each claim by 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.

REPORT: CRA-TRAN-R  
 RA#: 99999999

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

DATE: 12/25/2020  
 PAGE: 157

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

PAYEE ID 9999999999  
 NPI ID 9999999999  
 CHECK/EFT NUMBER E999999999  
 ISSUE DATE 12/25/2020

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

| --CCN-- | REFUND --AMOUNT-- | ICN REFUNDED | REASON CODE | REASON DESCRIPTION |
|---------|-------------------|--------------|-------------|--------------------|
|---------|-------------------|--------------|-------------|--------------------|

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

| A/R NUMBER/ICN | SETUP DATE | RECD/RECPD THIS CYCLE | ORIGINAL AMOUNT | A/R INC/DEC | TOTAL RECD/RECP | INT CALC | INT RECD | BALANCE | REASON CODE |
|----------------|------------|-----------------------|-----------------|-------------|-----------------|----------|----------|---------|-------------|
| 999999999999   | 122520     | 44.49                 | 44.49           | 0.00        | 44.49           | -0.00    | 0.00     | 0.00    | 8400        |

Member id: 0000000000

## 8.9 Financial Transaction Page

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

### 8.9.1 Non-Claim Specific Payouts to Providers

| FIELD              | DESCRIPTION                                                                                             |
|--------------------|---------------------------------------------------------------------------------------------------------|
| TRANSACTION NUMBER | The tracking number assigned to each financial transaction.                                             |
| CCN                | The cash control number (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.                                                                            |

### 8.9.2 Non-Claim Specific Refunds from Providers

| FIELD         | DESCRIPTION                                                                       |
|---------------|-----------------------------------------------------------------------------------|
| CCN           | The cash control tracking number assigned to refund checks for tracking purposes. |
| REFUND AMOUNT | The amount refunded by 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.                                                      |

### 8.9.3 Accounts Receivable

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



| FIELD           | DESCRIPTION                                                                                                              |
|-----------------|--------------------------------------------------------------------------------------------------------------------------|
| 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.**

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 E999999999  
 ISSUE DATE 01/08/2021

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

|                      | CURRENT<br>NUMBER | CURRENT<br>AMOUNT | MONTH-TD<br>NUMBER | MONTH-TD<br>AMOUNT | YEAR-TD<br>NUMBER | YEAR-TD<br>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 |

REPORT: CRA-EOBM-R  
 RA#: 99999999

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

DATE: 12/11/2020  
 PAGE: 14

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

PAYEE ID 9999999999  
 NPI ID  
 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.                                                                                                                                            |

## 8.10 Summary Page

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

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

### 8.10.1 Payments

| 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 total.                                          |

**EXPLANATION OF BENEFITS**

| <b>FIELD</b>         | <b>DESCRIPTION</b>                                                                                                       |
|----------------------|--------------------------------------------------------------------------------------------------------------------------|
| 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**

| <b>FIELD</b>            | <b>DESCRIPTION</b>                                                                                                             |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| 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**

| <b>FIELD</b>                | <b>DESCRIPTION</b>                                                                                                                     |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| 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**

| <b>FIELD</b>            | <b>DESCRIPTION</b>                                                                                                       |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------|
| 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.                                              |

## 9 Appendix C – 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:

| 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               |

## 10 Appendix D – 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:

| 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                   |

Appendix D – Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

| <b>Code</b> | <b>Description</b>                                                 | <b>Code</b> | <b>Description</b>             |
|-------------|--------------------------------------------------------------------|-------------|--------------------------------|
| 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<br>Post Payment Review Contractor A | RP          | Recoupment Payout              |



Appendix D – Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

| <b>Code</b> | <b>Description</b>                                              | <b>Code</b> | <b>Description</b>              |
|-------------|-----------------------------------------------------------------|-------------|---------------------------------|
| 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                                    |             |                                 |

## 11 Appendix E – Remittance Advice Status Code (ST CD)

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

| 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               |

## 12 Appendix F – School Based Health Services

### 12.1 Procedural Coding for School Based Health Services

Procedure codes for School Based Health Services are as follows:

| Code                                    | Description                                                                                    |
|-----------------------------------------|------------------------------------------------------------------------------------------------|
| <b>NURSING SERVICES</b>                 |                                                                                                |
| T1002                                   | RN SERVICES UP TO 15 MINUTES                                                                   |
| T1003                                   | LPN/LVN SERVICES UP TO 15MIN                                                                   |
| T1004                                   | SERVICES OF A QUALIFIED NURSING AIDE, UP TO 15 MINUTES                                         |
| <b>PHYSICAL THERAPY SERVICES</b>        |                                                                                                |
| 97110                                   | THERAPEUTIC EXERCISES, EACH 15 MINUTES                                                         |
| <b>OCCUPATIONAL THERAPY SERVICES</b>    |                                                                                                |
| 97530                                   | THERAPEUTIC ACTIVITIES ONE-ON-ONE CONTACT BETWEEN PATIENT AND PROVIDER, EACH 15 MINUTES        |
| <b>SPEECH/LANGUAGE THERAPY SERVICES</b> |                                                                                                |
| 92507                                   | TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER        |
| 92508                                   | SPEECH/HEARING THERAPY GROUP TREATMENT                                                         |
| 92521                                   | EVALUATION OF SPEECH FLUENCY                                                                   |
| 92522                                   | EVALUATION OF SPEECH SOUND PRODUCTION                                                          |
| 92523                                   | EVALUATION OF SPEECH SOUND PRODUCTION WITH EVALUATION OF LANGUAGE COMPREHENSION AND EXPRESSION |
| 92524                                   | BEHAVIORAL AND QUALITATIVE ANALYSIS OF VOICE AND RESONANCE                                     |
| <b>HEARING/AUDIOLOGY SERVICES</b>       |                                                                                                |
| 92551                                   | AIR TONE CONDUCTION HEARING ASSESSMENT SCREENING                                               |
| <b>INCIDENTAL INTERPRETER SERVICES</b>  |                                                                                                |
| T1013                                   | SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES, PER 15 MINUTES                                    |

| Code                                     | Description                                                                                                             |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <b>ORIENTATION AND MOBILITY SERVICES</b> |                                                                                                                         |
| 97533                                    | SENSORY TECHNIQUE TO ENHANCE PROCESSING AND ADAPTATION TO ENVIRONMENTAL DEMANDS, EACH 15 MINUTES                        |
| <b>BEHAVIORAL SERVICES</b>               |                                                                                                                         |
| 96150                                    | HEALTH AND BEHAVIOR EVALUATION, EACH 15 MINUTES                                                                         |
| 96153                                    | HEALTH AND BEHAVIOR INTERVENTION, GROUP, EACH 15 MINUTES                                                                |
| <b>SPECIALIZED TRANSPORT SERVICES</b>    |                                                                                                                         |
| A0160                                    | NON-EMERGENCY TRANSPORTATION: PER MILE, CASE WORKER OR SOCIAL WORKER                                                    |
| <b>ASSISTIVE TECHNOLOGY</b>              |                                                                                                                         |
| E1399                                    | DURABLE MEDICAL EQUIPMENT – MISC                                                                                        |
| <b>MENTAL HEALTH ASSESSMENT</b>          |                                                                                                                         |
| H0031                                    | MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN                                                                              |
| <b>MENTAL HEALTH SERVICE PLAN</b>        |                                                                                                                         |
| H0032                                    | MENTAL HEALTH SERVICE PLAN DEVELOPMENT BY NON-PHYSICIAN                                                                 |
| 90853                                    | GROUP PSYCHOTHERAPY                                                                                                     |
| 90887                                    | CONSULTATION WITH FAMILY – EXPLANATION OF PSYCHIATRIC, MEDICAL EXAMINATIONS, PROCEDURES, AND DATA TO OTHER THAN PATIENT |

**Notes:**

- All procedure codes require modifiers except A0160, E1399, T1002, T1003, and T1004
- One unit equals 15 minutes except for the following procedure codes:
  - E1399, one unit equals one item
  - A0160, one unit equals one mile

## 12.2 Modifiers

Modifiers for the School Based Health Services codes are:

| Modifier | Description                                                                          |
|----------|--------------------------------------------------------------------------------------|
| AH       | CLINICAL PSYCHOLOGIST                                                                |
| AJ       | CLINICAL SOCIAL WORKER                                                               |
| GN       | SERVICES DELIVERED UNDER AN OUTPATIENT <b>SPEECH LANGUAGE</b> PATHOLOGY PLAN OF CARE |
| GN, U3   | SPEECH PATHOLOGY ASSISTANT                                                           |
| GO       | SERVICES DELIVERED UNDER AN <b>OUTPATIENT OCCUPATIONAL</b> THERAPY PLAN OF CARE      |
| GO, U3   | OCCUPATIONAL THERAPIST ASSISTANT                                                     |
| GO, UA   | OCCUPATIONAL THERAPIST AIDE                                                          |
| GP       | SERVICES DELIVERED UNDER AN OUTPATIENT <b>PHYSICAL THERAPY</b> PLAN OF CARE          |
| GP, U3   | PHYSICAL THERAPIST ASSISTANT                                                         |
| GP, UA   | PHYSICAL THERAPIST AIDE                                                              |
| HL       | INTERN                                                                               |
| HO       | MASTERS DEGREE LEVEL                                                                 |
| HP       | DOCTORAL LEVEL                                                                       |
| SA       | NURSE PRACTITIONER RENDERING SERVICE IN COLLABORATION WITH A PHYSICIAN               |
| TD       | RN                                                                                   |
| TE       | LPN/LVN                                                                              |
| U1       | MEDICAID LEVEL OF CARE 1, AS DEFINED BY STATE                                        |
| U2       | MEDICAID LEVEL OF CARE 2, AS DEFINED BY STATE                                        |
| U3       | MEDICAID LEVEL OF CARE 3, AS DEFINED BY STATE                                        |
| U4       | LICENSED COUNSELING PSYCHOLOGIST                                                     |
| U4, HP   | SCHOOL PSYCHOLOGIST, DOCTORAL LEVEL                                                  |
| U4, HO   | SCHOOL PSYCHOLOGIST, MASTER'S DEGREE LEVEL                                           |
| U5       | CERTIFIED PSYCHOLOGIST                                                               |
| U5, HO   | CERTIFIED PSYCHOLOGIST, MASTER LEVEL                                                 |
| U6       | MEDICAID LEVEL OF CARE 6, AS DEFINED BY STATE                                        |

| Modifier | Description                                    |
|----------|------------------------------------------------|
| U6, HO   | PSYCHOLOGICAL ASSOCIATE (MASTERS)              |
| U7       | SOCIAL WORKER                                  |
| U8       | GUIDANCE COUNSELOR                             |
| U9       | PSYCHOMETRIST                                  |
| UA       | MEDICAID LEVEL OF CARE 10, AS DEFINED BY STATE |
| UB       | INTERPRETER                                    |
| UC       | ORIENTATION AND MOBILITY                       |
| UD       | RESPIRATORY THERAPIST                          |

### 13 Appendix G – Place of Service

The Place of Service codes provide information on the location where the service occurred.

| Place of Service | Description                                                                             |
|------------------|-----------------------------------------------------------------------------------------|
| 02               | Telehealth (effective date of service 01/01/2018)                                       |
| 03               | School (effective date of service 07/01/2015)                                           |
| 04               | Homeless Shelter (effective date of service 07/01/2015)                                 |
| 10               | Telehealth Provided in Patient's Home (dates of service on or after 01/01/2022)         |
| 11               | Office (effective date of service 07/01/2015)                                           |
| 12               | Home (effective date of service 07/01/2015)                                             |
| 14               | Group Home (effective date of service 07/01/2015)                                       |
| 15               | Mobile Unit (effective date of service 07/01/2015)                                      |
| 16               | Temporary Lodging (effective date of service 07/01/2015)                                |
| 19               | Off Campus – Outpatient Hospital (dates of service on or after 02/01/2016)              |
| 22               | Outpatient Hospital (effective date of service 07/01/2015)                              |
| 33               | Custodial Care Facility (effective date of service 07/01/2015)                          |
| 49               | Independent Clinic (effective date of service 07/01/2015)                               |
| 50               | Federally Qualified Health Center (effective date of service 07/01/2015)                |
| 53               | Community Mental Health Center (effective date of service 07/01/2015)                   |
| 62               | Comprehensive Outpatient Rehabilitation Facility (effective date of service 07/01/2015) |
| 71               | Public Health Clinic (effective date of service 07/01/2015)                             |
| 72               | Rural Health Clinic (effective date of service 07/01/2015)                              |
| 99               | Other (end dated 06/30/2015)                                                            |

## 14 Appendix H – Acronyms

The following acronyms are used in this document:

| <b>Acronym</b> | <b>Description</b>                                  |
|----------------|-----------------------------------------------------|
| A/R, AR        | Accounts Receivable                                 |
| BCCTP          | Breast & Cervical Cancer Treatment Program          |
| CAP            | Corrective Action Plan                              |
| CCN            | Cash Control Number                                 |
| CDR            | Claim Detail Requests                               |
| CHW            | Community Health Workers                            |
| CLM            | Claim                                               |
| CMS            | Centers for Medicare and Medicaid Services          |
| CR             | Credit                                              |
| DCBS           | Department for Community Based Services             |
| DMS            | Department for Medicaid Services                    |
| DOS            | Date of Service                                     |
| DRG            | Diagnosis Related Group                             |
| E&M            | Evaluation and Management                           |
| ECS            | Electronic Claims Submission                        |
| EDI            | Electronic Data Interchange                         |
| EOB            | Explanation of Benefits                             |
| EOMB           | Explanation of Medicare Benefits                    |
| EPA            | Electronic Prior Authorization                      |
| EPSDT          | Early Periodic Screening, Diagnosis, and Treatment  |
| FFP            | Federal Financial Participation                     |
| FIN            | Financial                                           |
| HIPAA          | Health Insurance Portability and Accountability Act |
| HOSP           | Hospital                                            |
| ICD            | International Classification of Diseases            |
| ICN            | Internal Control Number                             |



| Acronym | Description                                   |
|---------|-----------------------------------------------|
| ID      | Identification                                |
| KCHIP   | Kentucky Children's Health Insurance Program  |
| KY      | Kentucky                                      |
| MCO     | Managed Care Organization                     |
| MMIS    | Medicaid Management Information System        |
| NPI     | National Provider Identifier                  |
| OCR     | Optical Character Recognition                 |
| PCP     | Primary Care Provider                         |
| PE      | Presumptive Eligibility                       |
| PRO     | Peer Review Organization                      |
| QMB     | Qualified Medicare Beneficiary                |
| RA      | Remittance Advice                             |
| RTP     | Return to Provider                            |
| SLMB    | Specified Low-Income Medicare Beneficiaries   |
| SURS    | Surveillance and Utilization Review Subsystem |
| TPL     | Third Party Liability                         |
| VREV    | Voice Response Eligibility Verification       |