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CABINET FOR HEALTH  
AND FAMILY SERVICES

**Commonwealth of Kentucky  
KY Medicaid**

**Provider Billing Instructions  
for  
Hospital Services  
Provider Type – 01**

Version 9.8  
January 2, 2025

## Document Change Log

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

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

Version	Date	Name	Comments
4.2 (4.4)	01/29/2010	Ron Chandler	Changed the date on the cover page to today's date per Stayce Towles.
4.3 (4.5)	3/8/2010	Ron Chandler	Inserted new provider rep list.
4.4 (4.6)	6/14/2010	Ron Chandler	Insert asterisk and comment in form locator 67 and 67 (A-Q) and table that comment refers to.
4.5 (4.7)	6/22/2010	Ron Chandler	Insert new UB04 forms per Patti George, revised tables in sections 5.2 and 5.4.
4.6 (4.8)	6/23/2010	Ron Chandler	Revise sections 5.2 and 5.4 form locator table. v4.5 – 4.6 are actually the same as revisions were made back-to-back and no publication would have been made.
4.7 (4.9)	8/6/2010	Ron Chandler	Revise sections 5.2, field 67, W. Added the word "admission."
4.8 (5.0)	9/27/2010	Patti George Ron Chandler	Deleted paper claim instructions for form locator 62 in both sections 5.2 & 5.4 per Patti George email.
4.9 (5.1)	11/16/2010	Patti George Ron Chandler	Revised per Patti George paper document with markup.
5.0 (5.2)	01/14/2011	Ann Murray	Updated global sections. v4.9 – 5.0 are actually the same as revisions were made back-to-back and no publication would have been made.
5.1 (5.3)	02/10/2011	Ann Murray	Added Revenue Code 948 to Appendix C and D per CO 15336.
5.2 (5.4)	05/04/2011	Patti George	Replace occurrences of SHPS with Carewise Health, Inc.
5.3 (5.5)	07/12/2011	Patti George	Add Discharge Status 21 per CO 13326.
5.4 (5.6)	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
5.5 (5.7)	12/20/2011	Stayce Towles Ann Murray	Added revenue code 615, 616 and 618 to Appendix B and C. DMS approved 01/04/2012, Alisha Clark.
5.8	02/08/2012	Stayce Towles Ann Murray	Updated the provider rep listing. DMS Approved 02/14/2012, John Hoffman.
5.9	02/22/2012	Brenda Orberson Ann Murray	Global updates made to remove all references to KenPAC and Lockin. DMS Approved 03/09/2012, John Hoffman.

Version	Date	Name	Comments
6.0	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman,
6.1	05/16/2012	Stayce Towles Ann Murray	Deleted outpatient flat rate charges per Alisha Clark at DMS. DMS approved 05/24/2012, Alisha Clark.
6.2	06/04/2012	Stayce Towles Ann Murray	Updated sections 8 and added section 6.6 Duplicate or Inappropriate Payments based upon HPE recommendation with DMS approval from Alisha Clark. DMS approved, Alisha Clark 06/20/2012.
6.3	08/30/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012.
6.4	11/26/2012	Vicky Hicks Patti George	Add revenue code 483 - Echo cardiology to the Outpatient Revenue Code list per Alisha Clark. DMS approved by Alisha Clark, 12/11/2012.
6.5	01/16/2013	Vicky Hicks Patti George	Update section 1.2.2.2 to reflect former Passport Members having a choice of MCOs as of 1/1/2013. DMS Approved 2/27/2013, John Hoffman.
6.6	06/04/2013	Vicky Hicks Patti George	Updates to NET PAYMENT and NET EARNINGS descriptions in Section 15.10.1. DMS Approved 07/09/2013, John Hoffman.
6.7	07/29/2013	Stayce Towles Patti George	Update section 5.10 - Provider Rep listing.
6.8	03/18/2014	Stayce Towles	Updated sections 1-5 per DMS. Approved 4-7-14 by Lee Guice.
6.9	05/07/2014	Stayce Towles	Per Harriett Devore DMS - Updated section 6.5.1 field 44 under CPT/rates corrected far as the first paragraph to say exactly the same thing as 6.3.1 field 44 that revenue codes 270-275 should be excluded. Approved 5/8/14, Harriett Devore.
7.0	07/30/2014	Stayce Towles	Updated requirements for revenue codes needing CPT's in FL 44. Approved, Charles Douglass 7/30/14.
7.1	08/08/2014	Stayce Towles	Added Revenue code 430 to outpatient services effective 7/4/14, per Charles Douglass.
7.2	01/30/2015	Stayce Towles	Added Revenue code 910 to outpatient services, effective 7/4/14, per Charles Douglass, DMS. Also, added GT modifier, form locator 66 and removed section 7.1.1 Outpatient Services

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

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

Version	Date	Name	Comments
9.5	02/16/2023	Vicky Hicks Mary Larson	Updated Medicare to include Medicare Part C and crossover text, where appropriate. Inserted a new Return to Provider letter. Reworded section 7.1 per Jennifer Swingle, DMS approved 2/16/2023.
9.6	03/13/2024	Vicky Hicks	Revisions to Section 6.3.1 Added H0038 remains a covered code but effective 1/1/2023 is billable with any revenue code other than 300 – 314, 360, 430, 450, 452, 456, 481, 682, 683, 684, and 900. Removed CPT list from 450 revenue code. Requested by Jennifer Swingle, DMS 03/11/2024
9.7	11/25/2024	Vicky Hicks	Added Section 9 Medicare Part B only. Approved by Jennifer Swingle, DMS, on November 25, 2024.
9.8	01/02/2025	Vicky Hicks Mary Larson	Updated the Provider Representative List, Contacts and Assigned Counties heading.



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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>

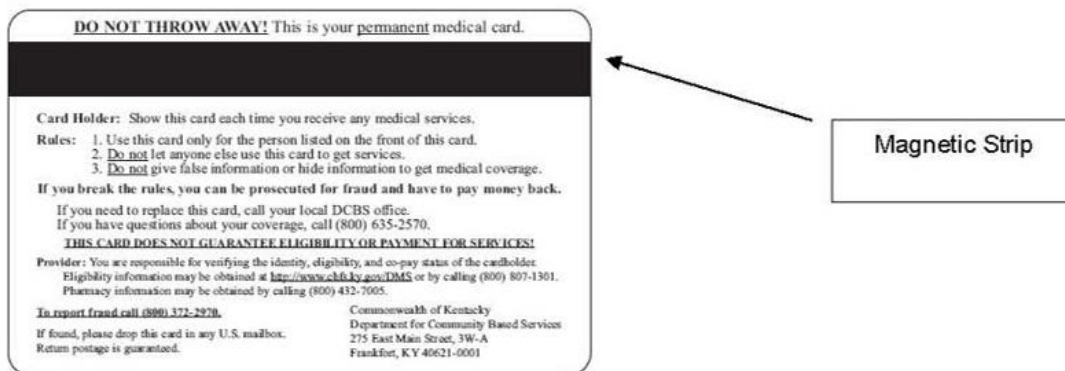
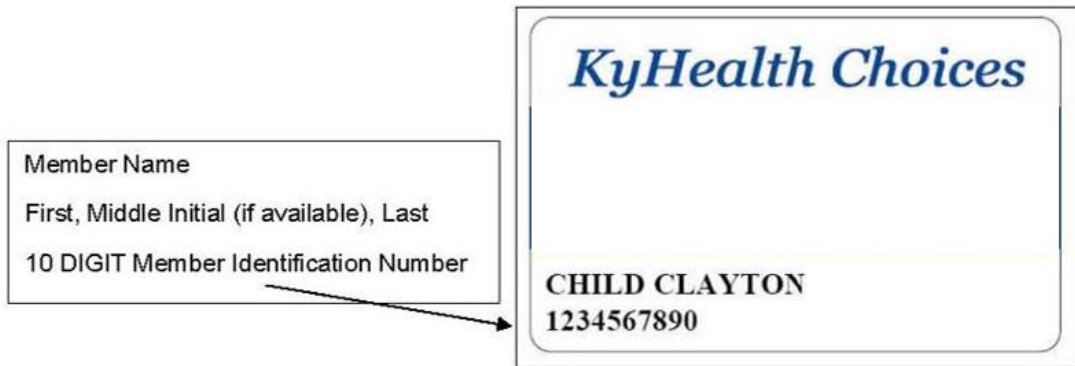
## 1.2 Member Eligibility

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 EDI Helpdesk@dx.com](mailto:KY_EDI_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 40602-2016  
1-800-205-4696

Help Desk hours are between 7:00 a.m. and 6:00 p.m. Monday through Friday, except holidays.

### **2.2 Format and Testing**

All EDI Trading Partners must test successfully with Gainwell and have Department for Medicaid Services (DMS) approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk at the phone number listed above for specific testing instructions and requirements.

### **2.3 Electronic Claims Submission Help**

Providers with questions regarding electronic claims submission (ECS) may contact the EDI Help desk.

---

### 3 KY HealthNet

The KY HealthNet website allows providers to submit claims online via a secure, direct data entry function. Providers with internet access may utilize the user-friendly claims wizard to submit claims, in addition to checking eligibility and other helpful functions.

#### 3.1 How to Get Started

All Providers are encouraged to utilize KY HealthNet rather than paper claims submission. To become a KY HealthNet user, contact our EDI helpdesk at 1-800-205-4696 or click the link below.

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

#### 3.2 KY HealthNet Companion Guides

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

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

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## 5 Additional Information and Forms

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

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

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

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

To process claims beyond the 12 month limit, you must attach to each claim form involved, a copy of a Claims in Process, Paid Claims, or Denied Claims section from the appropriate Remittance Statement no more than 12 months old, which verifies that the original claim was received within 12 months of the service date. Proof of timely filing documentation must show that the claim has been received and processed at least once every twelve month period from the service date.

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

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

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

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

### 5.3 Unacceptable Documentation

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

## 5.4 Third Party Coverage Information

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

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

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

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

1. Remittance statement from the insurance carrier that includes:
  - a. Member name
  - b. Date(s) of service
  - c. Billed information that matches the billed information on the claim submitted to Medicaid

**and**

- d. An indication of denial or that the billed amount was applied to the deductible

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

2. Letter from the insurance carrier that includes:
    - a. Member name
    - b. Date(s) of service(s)
    - c. Termination or effective date of coverage (if applicable)
    - d. Statement of benefits available (if applicable)
- and**
- e. The letter must have a signature of the insurance representative or be on the insurance company’s letterhead
  3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:
    - a. Member name
    - b. Date(s) of service
    - c. Name of insurance carrier
    - d. Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached
    - e. Termination or effective date of coverage

**and**

- f. Statement of benefits available (if applicable)
4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:
  - a. For the same member

b. For the same or related service being billed on the claim

**and**

c. The date of service specified on the remittance advice is no more than six months prior to the claim's date of service

**Note:** If the remittance statement does not provide a date of service, the denial may only be acceptable by Gainwell if the date of the remittance statement is no more than six months from the claim's date of service.

5. Letter from an employer that includes:

a. Member name

b. Date of insurance or employee termination or effective date (if applicable)

**and**

c. Employer letterhead or signature of company representative

#### **5.4.3 When there is No Response within 120 Days from the Insurance Carrier**

When the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim, a provider may complete a TPL Lead Form. Write "no response in 120 days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to Gainwell. Gainwell overrides the other health insurance edits and forwards a copy of the TPL Lead Form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability.

#### **5.4.4 For Accident and Work-Related Claims**

For claims related to an accident or work-related incident, the provider should pursue information relating to the event. If an employer, individual, or an insurance carrier is a liable party but the liability has not been determined, claims may be submitted to Gainwell with an attached letter containing any relevant information, such as, names of attorneys, other involved parties, and/or the member's employer to:

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

**5.4.4.1 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 KYMMIS website to obtain blank Prior Authorization forms:

<http://www.kymmisis.com/kymmisis/Provider%20Relations/PriorAuthorizationForms.aspx>

Access to an Electronic Prior Authorization (EPA) request:

<https://home.kymmisis.com>

## 5.7 Adjustments and Void Requests

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

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

Please keep the following points in mind when filing an adjustment request:

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form
  - For a Medicaid/Medicare or Medicare Part C (Medicare Advantage) crossover, attach an Explanation of Medicare Benefits (EOMB) to the claim
- Do not send refunds on claims for which an adjustment has been filed
- Be specific, explain exactly what is to be changed on the claim
- Claims showing paid zero-dollar amounts are considered paid claims by Medicaid; if the paid amount of zero is incorrect, the claim requires an adjustment
- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely

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: <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 or Medicare Part C (Medicare Advantage)/Medicaid crossover claims

Other reasons for return may include:

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





**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 Martha.Senn@gainwelltechnologies.com			Whitney Cole Whitneyc@gainwelltechnologies.com		
Assigned Counties			Assigned Counties		
ADAIR	GREEN	MCCREARY	ANDERSON	GARRARD	MENIFEE
ALLEN	HART	MCLEAN	BATH	GRANT	MERCER
BALLARD	HARLAN	METCALFE	BOONE	GRAYSON	MONTGOMERY
BARREN	HENDERSON	MONROE	BOURBON	GREENUP	MORGAN
BELL	HICKMAN	MUHLENBERG	BOYD	HANCOCK	NELSON
BOYLE	HOPKINS	OWSLEY	BRACKEN	HARDIN	NICHOLAS
BREATHITT	JACKSON	PERRY	BRECKINRIDGE	HARRISON	OHIO
CALDWELL	KNOX	PIKE	BULLITT	HENRY	OLDHAM
CALLOWAY	KNOTT	PULASKI	BUTLER	JEFFERSON	OWEN
CARLISLE	LARUE	ROCKCASTLE	CAMPBELL	JESSAMINE	PENDLETON
CASEY	LAUREL	RUSSELL	CARROLL	JOHNSON	POWELL
CHRISTIAN	LESLIE	SIMPSON	CARTER	KENTON	ROBERTSON
CLAY	LETCHER	TAYLOR	CLARK	LAWRENCE	ROWAN
CLINTON	LINCOLN	TODD	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 UB-04 Paper Claim Form with NPI

### 6.1 UB-04 Billing with NPI Instructions

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

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

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

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

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

6.2 UB-04 Claim Form with NPI and Taxonomy

1 Provider Name	2	3a PAT. CNTL. #	Patient Control Number	4 TYPE OF BILL
Street Address		b. MED. REC. #		0111
City or Town	ST ZIP	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH
AC+Phone Number			010107	013107
8 PATIENT NAME	a	9 PATIENT ADDRESS	a	
b		c	d	e
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE
01021900		010107	01	1
15 SRC	16 DHR	17 STAT	18	19
13	01	c1		
20	21	22	23	24
25	26	27	28	29
30	31	32	33	34
OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE
11	010107			
35	36	37	38	39
OCCURRENCE SPAN FROM	OCCURRENCE SPAN THROUGH	OCCURRENCE SPAN FROM	OCCURRENCE SPAN THROUGH	OCCURRENCE SPAN FROM
40	41	42	43	44
VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT
a	b	c	d	e
80	30			
45	46	47	48	49
REV. CD.	DESCRIPTION	HCPCS / RATE / HIPPS CODE	SERV. DATE	SERV. UNITS
120	ROOM CHARGES			30
250	PHARMACY			98
47	TOTAL CHARGES	48	NON-COVERED CHARGES	49
				00
				00
23	0001	PAGE	OF	CREATION DATE
TOTALS				30,688.00
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS
KyHealth Choices				
55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID	58	59
	Pay To NPI #	Pay To Taxonomy #	Facility Zip Code	
58 INSURED'S NAME	59 PPEL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
JANE DOE		4000000000		
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	66	67
01234567				
68 DX	69	70	71	72
234.5				
73	74	75	76	77
ADMIT. DATE	PATIENT REASON DX	PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	OTHER PROCEDURE CODE
234.5		123.4	010207	
78	79	80	81	82
ATTENDING NPI	QUAL	LAST	FIRST	MIDDLE
Attending NPI#		JONES	JAMES	
83	84	85	86	87
OPERATING NPI	QUAL	LAST	FIRST	MIDDLE
88	89	90	91	92
OTHER NPI	QUAL	LAST	FIRST	MIDDLE
93	94	95	96	97
OTHER NPI	QUAL	LAST	FIRST	MIDDLE
80 REMARKS	81 CC	82	83	84
	a	b	c	d



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

#### 6.3.1 Detailed Instructions

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

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION								
1	<p><b>Provider Name, Address, and Telephone</b></p> <p>Enter the complete name, address, and telephone number (including area code) of the facility.</p>								
3	<p><b>Patient Control Number</b></p> <p>Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.</p>								
4	<p><b>Type of Bill</b></p> <p>Enter the appropriate code to indicate the type of bill (TOB).</p> <table border="1" data-bbox="407 848 1414 1377"> <tbody> <tr> <td data-bbox="407 848 704 905">1st Digit</td> <td data-bbox="704 848 1414 905">Enter zero</td> </tr> <tr> <td data-bbox="407 905 704 995">2nd Digit (Type of Facility)</td> <td data-bbox="704 905 1414 995">1 = Hospital</td> </tr> <tr> <td data-bbox="407 995 704 1167">3rd Digit (Bill Classification)</td> <td data-bbox="704 995 1414 1167">                     1 = Inpatient (including Medicare Part A)                      2 = Inpatient (Medicare Part B only)                      3 = Outpatient                      4 = Non-patient                 </td> </tr> <tr> <td data-bbox="407 1167 704 1377">4th Digit (Frequency)</td> <td data-bbox="704 1167 1414 1377">                     0 = Non-payment                      1 = Admit through discharge                      2 = Interim, first claim                      3 = Interim, continuing claim                      4 = Interim, final claim                 </td> </tr> </tbody> </table> <p>Example: TOB 0131 has been established and must be used to identify outpatient services.</p> <p>For dates of service 04/01/2003 and after, the TOB must be 0111 for inpatient claims except for critical access, rehabilitation, and psychiatric hospitals.</p> <p>For newborn claims, TOB 0110 is to be used while mom and newborn are in the same facility.</p> <p>DRG facilities are to use TOB 0111 for newborn claims effective October 15, 2007.</p>	1st Digit	Enter zero	2nd Digit (Type of Facility)	1 = Hospital	3rd Digit (Bill Classification)	1 = Inpatient (including Medicare Part A) 2 = Inpatient (Medicare Part B only) 3 = Outpatient 4 = Non-patient	4th Digit (Frequency)	0 = Non-payment 1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
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6	<p><b>Statement Covers Period</b></p> <p>FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).</p>								

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION																																																				
	<p><b>THROUGH:</b> Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).</p> <p>Do not include days prior to when the member's KY Medicaid eligibility period began.</p> <p>The "FROM" date is the date of the admission if the member was eligible for the KY Medicaid benefits upon admission. If the member was not eligible on the date of admission, the "FROM" date is the effective date of eligibility.</p> <p>The "THROUGH" date is the last covered day of the hospital stay.</p>																																																				
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12	<p><b>Admission Date</b></p> <p>Enter the date on which the member was admitted to the facility in numeric format (MMDDYY).</p>																																																				
13	<p><b>Admission Hour</b></p> <p>Enter the code for the time of admission to the facility. The admission hour is required for both inpatient and outpatient services.</p> <p><b>CODE STRUCTURE</b></p> <table border="1" data-bbox="407 1003 1414 1726"> <thead> <tr> <th data-bbox="407 1003 524 1058">CODE</th> <th data-bbox="524 1003 911 1058">TIME A.M.</th> <th data-bbox="911 1003 1027 1058">CODE</th> <th data-bbox="1027 1003 1414 1058">TIME P.M.</th> </tr> </thead> <tbody> <tr> <td data-bbox="407 1058 524 1113">00</td> <td data-bbox="524 1058 911 1113">12:00 – 12:59 (midnight)</td> <td data-bbox="911 1058 1027 1113">12</td> <td data-bbox="1027 1058 1414 1113">12:00 – 12:59 (noon)</td> </tr> <tr> <td data-bbox="407 1113 524 1167">01</td> <td data-bbox="524 1113 911 1167">01:00 – 01:59</td> <td data-bbox="911 1113 1027 1167">13</td> <td data-bbox="1027 1113 1414 1167">01:00 – 01:59</td> </tr> <tr> <td data-bbox="407 1167 524 1222">02</td> <td data-bbox="524 1167 911 1222">02:00 – 02:59</td> <td data-bbox="911 1167 1027 1222">14</td> <td data-bbox="1027 1167 1414 1222">02:00 – 02:59</td> </tr> <tr> <td data-bbox="407 1222 524 1276">03</td> <td data-bbox="524 1222 911 1276">03:00 – 03:59</td> <td data-bbox="911 1222 1027 1276">15</td> <td data-bbox="1027 1222 1414 1276">03:00 – 03:59</td> </tr> <tr> <td data-bbox="407 1276 524 1331">04</td> <td data-bbox="524 1276 911 1331">04:00 – 04:59</td> <td data-bbox="911 1276 1027 1331">16</td> <td data-bbox="1027 1276 1414 1331">04:00 – 04:59</td> </tr> <tr> <td data-bbox="407 1331 524 1386">05</td> <td data-bbox="524 1331 911 1386">05:00 – 05:59</td> <td data-bbox="911 1331 1027 1386">17</td> <td data-bbox="1027 1331 1414 1386">05:00 – 05:59</td> </tr> <tr> <td data-bbox="407 1386 524 1440">06</td> <td data-bbox="524 1386 911 1440">06:00 – 06:59</td> <td data-bbox="911 1386 1027 1440">18</td> <td data-bbox="1027 1386 1414 1440">06:00 – 06:59</td> </tr> <tr> <td data-bbox="407 1440 524 1495">07</td> <td data-bbox="524 1440 911 1495">07:00 – 07:59</td> <td data-bbox="911 1440 1027 1495">19</td> <td data-bbox="1027 1440 1414 1495">07:00 – 07:59</td> </tr> <tr> <td data-bbox="407 1495 524 1549">08</td> <td data-bbox="524 1495 911 1549">08:00 – 08:59</td> <td data-bbox="911 1495 1027 1549">20</td> <td data-bbox="1027 1495 1414 1549">08:00 – 08:59</td> </tr> <tr> <td data-bbox="407 1549 524 1604">09</td> <td data-bbox="524 1549 911 1604">09:00 – 09:59</td> <td data-bbox="911 1549 1027 1604">21</td> <td data-bbox="1027 1549 1414 1604">09:00 – 09:59</td> </tr> <tr> <td data-bbox="407 1604 524 1659">10</td> <td data-bbox="524 1604 911 1659">10:00 – 10:59</td> <td data-bbox="911 1604 1027 1659">22</td> <td data-bbox="1027 1604 1414 1659">10:00 – 10:59</td> </tr> <tr> <td data-bbox="407 1659 524 1726">11</td> <td data-bbox="524 1659 911 1726">11:00 – 11:59</td> <td data-bbox="911 1659 1027 1726">23</td> <td data-bbox="1027 1659 1414 1726">11:00 – 11:59</td> </tr> </tbody> </table>	CODE	TIME A.M.	CODE	TIME P.M.	00	12:00 – 12:59 (midnight)	12	12:00 – 12:59 (noon)	01	01:00 – 01:59	13	01:00 – 01:59	02	02:00 – 02:59	14	02:00 – 02:59	03	03:00 – 03:59	15	03:00 – 03:59	04	04:00 – 04:59	16	04:00 – 04:59	05	05:00 – 05:59	17	05:00 – 05:59	06	06:00 – 06:59	18	06:00 – 06:59	07	07:00 – 07:59	19	07:00 – 07:59	08	08:00 – 08:59	20	08:00 – 08:59	09	09:00 – 09:59	21	09:00 – 09:59	10	10:00 – 10:59	22	10:00 – 10:59	11	11:00 – 11:59	23	11:00 – 11:59
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14	<p><b>Admission Type</b>            Enter the appropriate type of admission:            1 = Emergency            2 = Urgent            3 = Elective            4 = Newborn</p>																																
16	<p><b>Discharge Hour</b>            Enter the code for the hour the member was discharged from the facility using the code structure described for Field 13 (above).</p>																																
17	<p><b>Patient Status Code</b>            Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the “through” date in Form Locator 6.  <b>Status Codes Accepted by KY Medicaid</b></p> <table border="1" data-bbox="407 852 1414 1839"> <tbody> <tr><td>01</td><td>Discharged to Home/Self Care</td></tr> <tr><td>02</td><td>Discharged to Another Hospital</td></tr> <tr><td>03</td><td>Discharged to Skilled Nursing Facility (SNF)</td></tr> <tr><td>04</td><td>Discharged to Intermediate Care Facility (ICF)</td></tr> <tr><td>05</td><td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital</td></tr> <tr><td>06</td><td>Discharged/Transferred to Home Under Care of Organized Home Health Service Organization</td></tr> <tr><td>07</td><td>Left Against Medical Advice</td></tr> <tr><td>10</td><td>Discharged/Transferred to a Psychiatric Hospital (end date 10/1/22)</td></tr> <tr><td>20</td><td>Expired</td></tr> <tr><td>21</td><td>Discharge or Transfer to Court/Law Enforcement</td></tr> <tr><td>30</td><td>Still a Patient</td></tr> <tr><td>40</td><td>Expired at Home</td></tr> <tr><td>41</td><td>Expired in a Medical Facility</td></tr> <tr><td>42</td><td>Expired – Place Unknown</td></tr> <tr><td>50</td><td>Discharged to Hospice – Home</td></tr> <tr><td>51</td><td>Discharged to Hospice Medical Facility</td></tr> </tbody> </table>	01	Discharged to Home/Self Care	02	Discharged to Another Hospital	03	Discharged to Skilled Nursing Facility (SNF)	04	Discharged to Intermediate Care Facility (ICF)	05	Discharged/Transferred to a Designated Cancer Center or Children’s Hospital	06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization	07	Left Against Medical Advice	10	Discharged/Transferred to a Psychiatric Hospital (end date 10/1/22)	20	Expired	21	Discharge or Transfer to Court/Law Enforcement	30	Still a Patient	40	Expired at Home	41	Expired in a Medical Facility	42	Expired – Place Unknown	50	Discharged to Hospice – Home	51	Discharged to Hospice Medical Facility
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FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION	
	61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (valid on crossover claims only)
	62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital
	63	Discharged/Transferred to a Medicare Certified Long Term Care Facility
	65	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a Hospital
	70	Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere
	82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
	83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
	85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
	86	Discharged/Transferred to Home under care of Organized Home
	90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission
	91	Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission
	93	Discharged/transferred to a psychiatric hospital/distinct part unit of a hospital with a planned acute care hospital inpatient readmission
18-28	<p><b>Condition Codes</b></p> <p>Peer Review Organization (PRO) Indicator</p> <p>Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee.</p> <p>    C1 = Approved as Billed</p> <p>    C2 = Automatic Approval as Billed Based on Focus Review</p> <p>    C3 = Partial Approval*</p> <p>*If the PRO authorized a portion of the member's hospital stay, the approved date(s) must be shown in Form Locator 36, Occurrence Span. These dates should be the same as the dates of service in Form Locator 6.</p>	



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

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
	<p>A2 = Coinsurance Payer A Enter the amount as shown on the EOMB to be applied toward the member's coinsurance amount due.</p> <p>A7 = Copayment Payer A Enter the amount as shown on the EOMB to be applied to the member's Medicare Part C copayment amount due.</p> <p>B1 = Deductible Payer B Enter the amount as shown on the EOMB to be applied to the member's deductible amount due.</p> <p>B2 = Coinsurance Payer B Enter the amount as shown on the EOMB to be applied toward the member's coinsurance amount due.</p> <p>B7 = Copayment Payer B Enter the amount as shown on the EOMB to be applied to the member's Medicare Part C copayment amount due.</p>
42	<p><b>Revenue Codes</b> Enter the three-digit revenue code identifying specific accommodation and ancillary services. A list of revenue codes covered by KY Medicaid is located in Appendices B and C of this manual.</p> <p>It is extremely important that the ancillary services reported on the UB-04 billing form be submitted by using the correct Revenue Codes. All approved Revenue Codes are listed in Appendices B and C of this manual. Incorrect billing of ancillary services or failure to correct any remarks may ultimately affect the in-state provider's prospective payment rate.</p> <p><b>Note:</b> Total charge Revenue code 0001 must be the final entry in column 42, line 23.</p> <p><b>Note:</b> The total charge amount must be shown in column 47, line 23.</p>
43	<p><b>Description</b> Enter the standard abbreviation assigned to each revenue code.</p> <p>Effective July 1, 2009, the National Drug Code (NDC) is required when billing outpatient services for revenue codes 250 – 253, 256 – 259, and 634 – 636. Revenue codes 254 and 255 are to be excluded from requiring NDC codes for outpatient hospital facilities. This will exclude radiopharmaceuticals and IV contrast media from being billed with NDCs. The N4 qualifier precedes the NDC. Do not use dashes or spaces. Example: N4XXXXXXXXXXXX.</p> <p>Enter only one NDC per line.</p>

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION																				
44	<p><b>CPT/RATES</b></p> <p>Outpatient claims require a CPT-4 procedure code to be billed only in conjunction with the revenue codes below.</p> <p>Revenue codes 300 – 314, 360, 430, 450, 452, 456, 481, 682, 683, 684, and 900 require a CPT-4 code.</p> <p>Revenue code 260 requires a CPT-4 effective 11/9/20. NOTE: Outpatient claims billed with Procedure codes M0239, M0243, or Q0239 must be billed with Revenue code 260.</p> <p>Revenue code 771 requires a CPT-4 effective 12/11/20.</p> <p>H0038 remains a covered code but effective 1/1/2023 is billable with any revenue code other than 300 – 314, 360, 430, 450, 452, 456, 481, 682, 683, 684, and 900.</p> <p>Revenue code 900 also requires the use of one of the following modifiers:</p> <table border="1" data-bbox="407 821 1414 1413"> <thead> <tr> <th>Modifiers</th> <th>Descriptions</th> </tr> </thead> <tbody> <tr> <td>AH</td> <td>Licensed Clinical Psychologist</td> </tr> <tr> <td>AJ</td> <td>Licensed Clinical Social Worker</td> </tr> <tr> <td>AM</td> <td>Physician (MD or DO)</td> </tr> <tr> <td>HO</td> <td>LPCC, LPAT, LBA</td> </tr> <tr> <td>SA</td> <td>ARNP</td> </tr> <tr> <td>U1</td> <td>Physician Assistant</td> </tr> <tr> <td>U4</td> <td>Associate to the Behavioral Health Providers – CSW, LPCA, LPA, LPATA, LABA, LMFTA</td> </tr> <tr> <td>U9</td> <td>Licensed Marriage and Family Therapist</td> </tr> <tr> <td>UA</td> <td>Certified Professional Counselor</td> </tr> </tbody> </table> <p>Modifier GT is applicable to the following services in an outpatient setting:                      Medical Nutrition Therapy, Individual Diabetes Self-Management Training, Physical Therapy, Speech Therapy, Occupational Therapy, End-Stage Renal Dialysis Monitoring, Assessment or Counseling for Home Dialysis, Physical Health Evaluation, Mental Health Evaluation, Individual or Group Psychotherapy, Pharmacologic Management, Psychiatric or Psychological, or Mental Health Diagnostic Interview, and Neurobehavioral Status Exam</p>	Modifiers	Descriptions	AH	Licensed Clinical Psychologist	AJ	Licensed Clinical Social Worker	AM	Physician (MD or DO)	HO	LPCC, LPAT, LBA	SA	ARNP	U1	Physician Assistant	U4	Associate to the Behavioral Health Providers – CSW, LPCA, LPA, LPATA, LABA, LMFTA	U9	Licensed Marriage and Family Therapist	UA	Certified Professional Counselor
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45	<p><b>Detail Date of Service</b></p> <p>Effective 08/01/2005, all outpatient claims require a detail date of service.</p>																				
45	<p><b>Creation Date</b></p> <p>Enter the invoice date or invoice creation date.</p>																				

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION
46	<p><b>Unit</b> Enter the quantitative measure of services provided per revenue code. Revenue Code 762 – Observation Room is measured as one unit and is equal to 23 hours or less.</p>
47	<p><b>Total Charges</b> Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry “total charges.” The claim total must be shown in field 47, line 23.</p>
48	<p><b>Non-Covered Charges</b> Enter the charges from Form Locator 47 that is non-payable by KY Medicaid.</p>
50	<p><b>Payer Identification</b> Enter the names of payer organizations from which the provider receives payment. For Medicaid, use <i>KY Medicaid</i>. All other liable payers, including Medicare or Medicare Part C (Medicare Advantage), must be billed first.* *KY Medicaid is the payer of last resort. <b>Note:</b> If you are billing with a primary carrier being a Medicare Part C (Medicare Advantage) policy, “Medicare” needs to be indicated in the payer name field along with the name of the Medicare C (Medicare Advantage) policy carrier. Example: Medicare United Healthcare or United Healthcare Medicare.</p>
54	<p><b>Prior Payments</b> Enter the paid amount from Medicare or Medicare Part C, if applicable. Enter the amount paid, if any, by private insurance.</p>
56	<p><b>NPI</b> Enter the Pay To National Provider Identifier (NPI) number.</p>
57	<p><b>Taxonomy</b> Enter the Pay To Taxonomy number.</p>
57B	<p><b>Other</b> Enter the facility’s zip code.</p>
58	<p><b>Insured’s Name</b> Enter the member’s name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the member’s name exactly as it appears on the member identification card in last name, first name, and middle initial format.</p>
60	<p><b>Identification Number</b> Enter the member identification number in Form Locators 60 A, B, and C that relates to the member’s name in Form Locators 58 A, B, and C. Enter the 10-</p>

FORM LOCATOR #	FORM LOCATOR NAME AND DESCRIPTION												
	digit member identification number exactly as it appears on the member identification card.												
63	<p><b>Prior Authorization Number</b></p> <p>Enter the prior authorization number assigned by the PRO/UR designating that the treatment covered by the bill is authorized by the PRO/UR.</p>												
66	<p><b>Diagnosis Indicator</b></p> <p>Enter the appropriate International Classification of Diseases (ICD) indicator:            9= ICD 9            0 = ICD 10</p>												
67	<p><b>Principal Diagnosis Code*</b></p> <p>Enter the ICD-10 Vol. 1 and 2 codes describing the principal diagnosis.</p> <p><b>*Effective dates of service July 1, 2010 and after, DRG facilities must indicate whether each diagnosis was present at the time of admission. Refer to the Present on Admission (POA) Indicators in the table below. The POA Indicator should follow the diagnosis code (in the shaded area in each field).</b></p> <table border="1" data-bbox="407 957 1414 1535"> <thead> <tr> <th data-bbox="407 957 646 1010">POA</th> <th data-bbox="646 957 1414 1010">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="407 1010 646 1062">Y (for yes)</td> <td data-bbox="646 1010 1414 1062">Present at the time of inpatient admission.</td> </tr> <tr> <td data-bbox="407 1062 646 1115">N (for no)</td> <td data-bbox="646 1062 1414 1115">Not present at the time of inpatient admission.</td> </tr> <tr> <td data-bbox="407 1115 646 1209">U (for unknown)</td> <td data-bbox="646 1115 1414 1209">The documentation is insufficient to determine if the condition was present at the time of inpatient admission.</td> </tr> <tr> <td data-bbox="407 1209 646 1304">W (for clinically undetermined)</td> <td data-bbox="646 1209 1414 1304">The provider is unable to clinically determine whether the condition was present at the time of admission.</td> </tr> <tr> <td data-bbox="407 1304 646 1535">1 (one) (for unreported/not used)</td> <td data-bbox="646 1304 1414 1535">           Diagnosis is exempt from POA reporting.  <b>Note:</b> The International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-10) Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting. Use POA indicator 1 only for codes on the list.         </td> </tr> </tbody> </table>	POA	Description	Y (for yes)	Present at the time of inpatient admission.	N (for no)	Not present at the time of inpatient admission.	U (for unknown)	The documentation is insufficient to determine if the condition was present at the time of inpatient admission.	W (for clinically undetermined)	The provider is unable to clinically determine whether the condition was present at the time of admission.	1 (one) (for unreported/not used)	Diagnosis is exempt from POA reporting. <b>Note:</b> The International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-10) Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting. Use POA indicator 1 only for codes on the list.
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W (for clinically undetermined)	The provider is unable to clinically determine whether the condition was present at the time of admission.												
1 (one) (for unreported/not used)	Diagnosis is exempt from POA reporting. <b>Note:</b> The International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-10) Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting. Use POA indicator 1 only for codes on the list.												
67A-Q	<p><b>Other Diagnosis Code</b></p> <p><b>Note:</b> Refer to instructions for field 67 for a table of Present on Admission (POA) indicators.</p> <p>Enter the ICD-10 Vol. 1 and 2 codes that co-exist at the time the service is provided.</p>												
69	<p><b>Admitting Diagnosis (Inpatient Only)</b></p> <p>Enter the ICD-10 diagnosis code describing the admitting diagnosis.</p>												

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

#### **6.4 Duplicate or Inappropriate Payments**

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

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

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

## 7 Special Billing Instructions

### 7.1 DRG

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

#### 7.1.1 Instructions on Submitting a Multiple Page UB-04

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

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

### 7.2 Medicaid Payment for Claims

#### 7.2.1 With Non-Covered Days Involving a Third Party

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

### **8.1 Professional Fees**

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

## 9 Medicare Part B Only

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

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

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

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

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

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

## 10 Form Requirements

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

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

**and**

- Other Services Statement (MAP-397)

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

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

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

MAP-236 (8/78)

#### CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH

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

my professional judgement, it was necessary to perform the following procedure on \_\_\_\_\_  
(Date)

to induce premature birth intended to produce a live viable child. \_\_\_\_\_  
(Procedure)

This Procedure was necessary for the health of \_\_\_\_\_  
(Name of Mother)

\_\_\_\_\_ of \_\_\_\_\_  
(MAID #) (Address)

and/or her unborn child.

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

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

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

\_\_\_\_\_  
Date

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

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

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

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

MAP-383 (Rev. 10/91)

**OTHER HOSPITALIZATION STATEMENT**

This is to certify that hospitalization at

\_\_\_\_\_ Name of Facility

for \_\_\_\_\_ beginning on  
 \_\_\_\_\_ Recipient Name/MAID Number

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

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

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

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

Signed: \_\_\_\_\_  
 \_\_\_\_\_ Medical Director

\_\_\_\_\_ Hospice Agency

\_\_\_\_\_ Date

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

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

If no, dates of previous admission \_\_\_\_\_

Diagnosis for previous admission \_\_\_\_\_  
 \_\_\_\_\_ ICD 9 CM Code

Approved by the Medicaid Program  Denied by the Medicaid Program

\_\_\_\_\_ Medicaid Signature

\_\_\_\_\_ Date

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

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

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



### 10.4 Example of Other Services Statement (MAP-397)

MAP-397 (Rev. 6/91)

#### Other Services Statement

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

\_\_\_\_\_

Name of Agency

for \_\_\_\_\_ beginning on \_\_\_\_\_

Member Name/MAID Number

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

Date

of this patient.

The reason for the service(s) is \_\_\_\_\_ / \_\_\_\_\_

Diagnosis ICD 9 CM Code

The patient's terminal illness is \_\_\_\_\_ / \_\_\_\_\_

Diagnosis ICD 9 CM Code

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

Signed: \_\_\_\_\_

Medical Director

\_\_\_\_\_

Hospice Agency

\_\_\_\_\_

Date

Durable Medical Equipment (List) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospital Outpatient Services (Please Describe Service/Reason) \_\_\_\_\_

\_\_\_\_\_

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

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

Yes  No

If no, date(s) of previous service \_\_\_\_\_

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

ICD 9 CM Code

\_\_\_\_\_ Approved by the Medicaid Program \_\_\_\_\_ Denied by the Medicaid Program

\_\_\_\_\_

Medicaid Signature Date

### 10.5 Completion of Other Services Statement (MAP-397)

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

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

## 11 Appendix A – Internal Control Number

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

**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

## 12 Appendix B – Inpatient Revenue Codes

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

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

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

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

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

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



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

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

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

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

### 12.1 Incremental Nursing Revenue Codes

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

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

### 13 Appendix C – Outpatient Revenue Codes

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

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

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

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

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



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

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

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

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

## 14 Appendix D – Inpatient and Outpatient Professional Component

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

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

## 15 Appendix E – Outpatient Drugs

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

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

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

## 16 Appendix F – Remittance Advice

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

### 16.1 Examples of Pages in a Remittance Advice

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

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

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. <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.

## 16.2 Title

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

REPORT: CRA-XBPD-R  
RA#: 99999999

COMMONWEALTH OF KENTUCKY  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE

DATE: 01/08/2021  
PAGE: 2

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

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

## 16.3 Banner Page

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

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



REPORT: CRA-IPPD-R  
 RA#: 99999999

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

DATE: 01/08/2021  
 PAGE: 2

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

--ICN--	ATTENDING PROV.	SERVICE DATES	DAYS	ADMIT	BILLED AMT	ALLOWED AMT	SPENDDOWN	PATIENT	TPL	PAID
PAT. ACCT NUM.		FROM THRU		DATE			COPAY AMT	LIABILITY	AMT	AMT
MEMBER NAME: JOHN DOE				MEMBER ID: 9999999999						
999999999999	9999999999	122920 123120	2	122920	10,366.81	0.00	0.00		0.00	3,846.59
9999999999							0.00	0.00		

HEADER EOB: 3001 9932

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

## 16.4 Paid Claims Page

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

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

REPORT: CRA-OPDN-R  
 RA#: 99999999

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

DATE: 01/08/2021  
 PAGE: 80

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

--ICN--	ATTEND PROV.	SERVICE DATES		BILLED	TPL	SPENDDOWN
--PATIENT NUMBER--		FROM	THRU	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JOHN DOE		MEMBER ID: 9999999999				
999999999999	9999999999	123120	123120	321.39	0.00	0.00
9999999999						

HEADER EOB: 1784

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

## 16.5 Denied Claims Page

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

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.
ATTENDING PROVIDER	The member's attending provider.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the member.
BILLED AMOUNT	The usual and customary charge for services provided for the member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.
CLAIM PMT. AMT.	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS DENIED ON THIS RA	The total number of denied claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on the final page of section).

REPORT: CRA-HHSU-R  
 RA#: 99999999

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

DATE: 01/08/2021  
 PAGE: 10

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

--ICN--	ATTEND PROV.	SERVICE DATES		BILLED	TPL	SPENDDOWN
--PATIENT NUMBER--		FROM	THRU	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JOHN DOE				MEMBER ID: 9999999999		
999999999999	9999999999	120320	123020	345.60	0.00	0.00
99999999999999999999						

LN	REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	DETAIL	EOBS
0001	270	T4535	120320		384.00	345.60	0505	9940
			Total:		384.00	345.60		

RELATED HISTORY - LINE	HISTORY ICN	DATE PAID
1	999999999999	20201211

## 16.6 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.
ATTENDING PROVIDER	The attending provider's NPI.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the member.
BILLED AMOUNT	The usual and customary charge for services provided for the member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.

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

-ICN-- REASON CODE  
99999999999999 01

CLAIMS RETURNED: 01

**16.7 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.





## 16.8 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 999999999  
 NPI ID 999999999  
 CHECK/EFT NUMBER E99999999  
 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
9999999999999999	122520	44.49	44.49	0.00	44.49	-0.00	0.00	0.00	8400
Member id: 0000000000									

## 16.9 Financial Transaction Page

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

### 16.9.1 Non-Claim Specific Payouts to Providers

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

### 16.9.2 Non-Claim Specific Refunds from Providers

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

### 16.9.3 Accounts Receivable

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

DATE: 01/08/2021  
 PAGE: 14

JD PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

SUMMARY

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

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

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

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

PAYMENTS:			
CLAIMS PAYMENTS	12,111.41	12,951.59	12,951.59
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
ACCOUNTS RECEIVABLE (OFFSETS):			
CLAIM SPECIFIC:			
CURRENT CYCLE	(0.00)	(0.00)	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC OFFSETS	(0.00)	(0.00)	(0.00)
TOTAL CLAIM PAYMENTS	12,111.41	12,951.59	12,951.59
REFUNDS:			
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)	(0.00)	(0.00)
OTHER FINANCIAL:			
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
VOIDS	(0.00)	(0.00)	(0.00)
NET EARNINGS	12,111.41	12,951.59	12,951.59

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.

## 16.10 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.  Mass Adjustments are initiated by Medicaid and Gainwell for issues that affect a large number of claims or providers. These adjustments have their own section “MASS ADJUSTED CLAIMS” page but are formatted the same as the ADJUSTED CLAIMS page.
CLAIMS DENIED	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
CLAIMS IN PROCESS	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

### 16.10.1 Payments

FIELD	DESCRIPTION
CLAIMS PAYMENT	The number of claims paid.
SYSTEM PAYOUTS	Any money owed to providers.
NET PAYMENT	The total check amount.
REFUNDS	Any money refunded to Medicaid by a provider.
OTHER FINANCIAL	This field appears on the Summary page when appropriate.
NET EARNINGS	The 1099 amount.



**EXPLANATION OF BENEFITS**

<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.

## 17 Appendix G – Remittance Advice Location Codes (LOC CD)

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

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

## 18 Appendix H – Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

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

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 H – 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 Post Payment Review Contractor A	RP	Recoupment Payout

Appendix H – 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		

## 19 Appendix I – 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

## 20 Appendix J – Acronyms

The following acronyms are used in this document:

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

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