Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions for Hospice Services Provider Type – 44

Version 6.6

January 2, 2025

Document Change Log

Version	Date	Name	Comments
1.0	10/14/2005	EDS	Initial creation of DRAFT Hospice Services Provider Type – 44.
1.1	01/19/2006	EDS	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	04/10/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.5	04/14/2006	Cathy Hill	Inserted RA samples; Inserted new Medicaid Hospice Election Form; Updated TOC. v1.2 – 1.5 are actually the same as revisions were made back-to-back and no publication would have been made.
1.6	06/14/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.7	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.8	10/30/2006	Ron Chandler	Insert UB-04 claim form and descriptors.
1.9	11/14/2006	Lize Deane	Revisions made according to comment log.
2.0	11/15/2006	Ann Murray	Inserted additional UB-04 instructions. v1.8 – 2.0 are actually the same as revisions were made back-to-back and no publication would have been made.
2.1	01/03/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
2.2	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
2.3	02/15/2007	Ann Murray	Updated Appendix B, KY Medicaid card and ICN.
2.4	02/21/2007	Ann Murray	Replaced Provider Rep table.
2.5	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v2.1 – 2.5 are actually the same as revisions were made back-to-back and no publication would have been made.
2.6	05/04/2007	Ann Murray	Updated and added claim forms and descriptors.

Version	Date	Name	Comments
2.7	05/15/2007	John McCormick	Updated IAW Comment Log. v2.6 – 2.7 are actually the same as revisions were made back-to-back and no publication would have been made.
2.8	06/20/07	John McCormick	Updated Rep List.
2.9	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.
3.0	06/11/2008	Ann Murray	Deleted without NPI claim and instructions; with NPI, Taxonomy and Legacy claim and instructions; and NPI and Legacy claim and instructions.
3.1	03/09/2009	Cathy Hill	Made changes from KYHealth Choices to KY Medicaid per Stayce Towles.
3.2	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept. for Medicaid Services per Stayce Towles.
3.3	03/30/2009	Ann Murray	Made global changes per DMS request. v3.1 – 3.3 are actually the same as revisions were made back-to-back and no publication would have been made.
3.4	09/08/2009	Ann Murray	Replaced Provider Rep list.
3.5	10/21/2009	Ron Chandler	Replace all instances of “EDS” with “HP Enterprise Services”.
3.6	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @hp.com. Removed the HIPAA section. v3.5 – 3.6 are actually the same as revisions were made back-to-back and no publication would have been made.
3.7	3/9/2010	Ron Chandler	Insert new provider rep list.
3.8	01/18/2011	Ann Murray	Updated global sections.
3.9	05/04/2011	Patti George	Replace occurrences of SHPS with Carewise Health, Inc.
4.0	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman.
4.1	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
4.2	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman.
4.3	06/22/2012	Stayce Towles Ann Murray	Updated sections 6.2.1, 6.4.1, and 13.1 based on HP recommendation and reviewed by DMS Ellenore Callan. DMS Approved 07/06/2012, Ellenore Callan.
4.4	08/31/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012.
4.5	01/31/2013	Vicky Hicks Patti George	Update section 1.2.2.2 to reflect former Passport Members having a choice of MCOs as of 1/1/2013. DMS Approved 02/27/2013, John Hoffman.
4.6	03/06/2013	Vicky Hicks Patti George	Update Section 7.3 MAP-384 Hospice Drug Form and Instructions DMS Approved, 02/07/2013, Ellenore Callan
4.7	06/27/2013	Vicky Hicks Patti George	Update section 13.1 - Replace Revenue Code 653 with Revenue Code 155, per CO16800. DMS Approved, 07/08/2013, David Dennis.
4.8	07/08/2013	Vicky Hicks Patti George	Updates to NET PAYMENT and NET EARNINGS descriptions in Section 9.10.1. DMS Approved 07/09/2013, John Hoffman.
4.9	08/13/2013	Stayce Towles Patti George	Update to section 5.10- Provider Rep listing.
5.0	04/09/2014	Stayce Towles	Update to sections 1 - 5 per DMS. Approved 4/9/14, Lee Guice.
5.1	07/10/2015	Stayce Towles	Add field 66 to the detailed billing instructions for ICD indicator. Approved by John Hoffmann, OATS, 7/6/15.
5.2	12/18/2015	Vicky Hicks	Updates to section 6 and Appendix F adding SIA changes. Approved by Gregg Stratton, DMS, 12/22/15.
5.3	2/9/2016	Vicky Hicks	Updated Rep List. Approved by Charles Douglass, DMS 2/9/16.
5.4	02/01/2017	Vicky Hicks	Added “Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. .For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com

Version	Date	Name	Comments
			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.
5.5	05/17/2019	Vicky Hicks Mary Larson	Updated: 1) HP/HPE to DXC, hpe.com to dxc.com, 2) Provider Rep Table, 3) all forms, 4) DMS URLs in Introduction, 5) ICD-9/ICD-9-CM to ICD-10.
5.6	10/11/2019	Vicky Hicks	Section 7.1 Changed Submitting MAP Forms "All Map forms should be submitted to: Carewise" to say Map 377, Map 383, Map 384 and Map 397 to be sent to Carewise. Send MAP forms 374, 375, 376, 378, 379, and 403 by fax to DMS at 502-564-0039 or email to DMS inbox at dms.eligibility@ky.gov. Approved 10/13/19 Kimberly Bickers, DMS.
5.7	07/17/2020	Vicky Hicks Mary Larson	Updated Provider Representative List extensions.
5.8	12/23/2020	Vicky Hicks Mary Larson	Updated the Cash Refund Documentation form. Form approved 03/06/2020 by John Hay, DMS. Updated *DXC Technology* to *Gainwell Technologies* or *Gainwell*, including all forms.
5.9	03/17/2021	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.
6.0	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.
6.1	01/10/2022	Vicky Hicks	Further definition to timely filing added. Approved by Justin Dearinger, DMS, 01/07/2022. Change Humana MCO name and phone number. Approved per John Hoffmann, 01/12/2022.
6.2	10/19/2022	Mary Larson	Updated logo on title page.
6.3	11/29/2022	Vicky Hicks Mary Larson	Updated MAP 383 and MAP 384. Approved by Kimberly Bickers, DMS 11/15/2022.
6.4	03/03/2023	Vicky Hicks Mary Larson	Inserted a new Return to Provider letter.

Version	Date	Name	Comments
6.5	10/11/2023	Vicky Hicks	Updated Section 7 Completion of MAP Forms Approved by Kimberly Bickers, DMS 10/10/2023
6.6	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 under Companion Guides and EDI Guides.

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

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

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

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

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

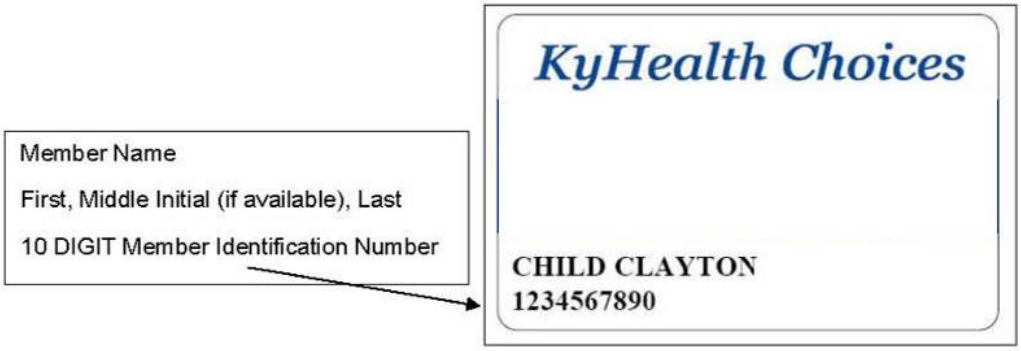
1.2 Member Eligibility

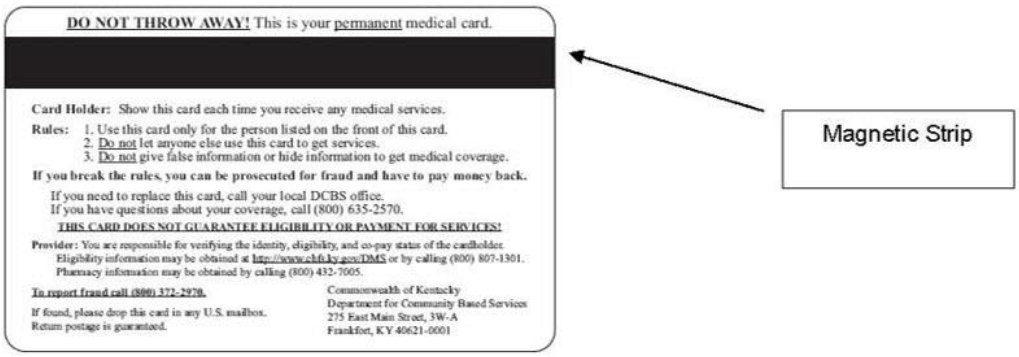
Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov) by phone at 1-855-4kynect (1-855-459-6328) or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through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

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

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

1.2.1 Plastic Swipe KY Medicaid Card





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

1.2.2 Member Eligibility Categories

1.2.2.1 QMB and SLMB

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

1.2.2.2 Managed Care Partnership

Medical benefits for persons whose care is overseen by a Managed Care Organization (MCO) are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with MCO questions should contact the respective MCO provider services:

- Passport Health Plan (now known as Molina) at 1-800-578-0775
- WellCare of Kentucky at 1-877-389-9457
- Humana Healthy Horizons in Kentucky at 1-800-444-9137
- 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

1.2.2.4.1 PE for Pregnant Women

1.2.2.4.1.1 Eligibility

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

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

Presumptive eligibility shall be granted to a woman if she:

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

and

- Is not an inmate of a public institution

1.2.2.4.1.2 Covered Services

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

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

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

1.2.2.4.2 PE for Hospitals

1.2.2.4.2.1 Eligibility

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

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

and

- Is not an inmate of a public institution

1.2.2.4.2.2 Covered Services

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

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

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

1.2.2.5 Breast & Cervical Cancer Treatment Program

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

1.2.3 Verification of Member Eligibility

This section covers:

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

1.2.3.1 Obtaining Eligibility and Benefit Information

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

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

1.2.3.1.1 Voice Response Eligibility Verification

Gainwell Technologies maintains a VREV system that provides member eligibility verification as well as information regarding third party liability (TPL), Managed Care, PRO review, card issuance, co-pay, provider check write, and claim status.

The VREV system-generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.

2. Prompt the caller to select the type of inquiry desired (eligibility, TPL, Managed Care, PRO review, card issuance, co-pay, provider check write, claim status, etc.).
3. Prompt the caller for the dates of service (enter four-digit year, for example, MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

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

1.2.3.1.2 KY HealthNet Online Member Verification

KY HealthNet online access can be obtained at https://home.kymmis.com. The KY HealthNet website is designed to provide real-time access to member information. Providers can download a User Manual to assist providers in system navigation. Providers with suggestions, comments, or questions should contact the Gainwell Electronic Claims Department at KY_EDI_Helpdesk@gainwelltechnologies.com or 1-800-205-4696.

All Member information is subject to Health Insurance Portability and Accountability Act (HIPAA) privacy and security provisions, and it is the responsibility of the provider and the provider's system administrator to ensure all persons with access understand the appropriate use of this data. It is suggested that providers establish office guidelines defining appropriate and inappropriate uses of this data.

2 Electronic Data Interchange

Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

2.1 How to Get Started

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the Gainwell Electronic Data Interchange Technical Support Help Desk at:

Gainwell Technologies
P.O. Box 2100
Frankfort, KY 40602-2100
1-800-205-4696

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

2.2 Format and Testing

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

2.3 Electronic Claims Submission Help

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

3 KY HealthNet

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

3.1 How to Get Started

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

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

3.2 KY HealthNet Companion Guides

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

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

4 General Billing Instructions for Paper Claim Forms

4.1 General Instructions

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

4.2 Imaging

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

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

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

4.3 Optical Character Recognition

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

5 Additional Information and Forms

5.1 Claims with Dates of Service More than One Year Old

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

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

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

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

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

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

5.2 Retroactive Eligibility (Back-Dated) Card

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

5.3 Unacceptable Documentation

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

5.4 Third Party Coverage Information

5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

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

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

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

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

   and

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

   Note: Rejections from insurance carriers stating "additional information necessary to process claim" is not acceptable.
2. Letter from the insurance carrier that includes:
   a. Member name
   b. Date(s) of service(s)
   c. Termination or effective date of coverage (if applicable)
   d. Statement of benefits available (if applicable)

   and

   e. The letter must have the 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

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.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx

Access to an Electronic Prior Authorization (EPA) request:

https://home.kymmis.com

5.7 Adjustments and Void Requests

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

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

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

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

Gainwell Technologies

ADJUSTMENT AND VOID REQUEST FORM

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

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

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

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

_____

_____

12. Please specify the REASON for the adjustment or void request.

_____

_____

_____

13. Signature _____ 14. Date _____

DMS Approved: December 7, 2020

5.8 Cash Refund Documentation Form

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

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

Please keep the following points in mind when refunding:

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

Gainwell Technologies

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

Make checks payable to:
Kentucky State Treasurer

CASH REFUND DOCUMENTATION

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

Research for Refund: (Check appropriate blank)

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

☐ b. Billed in error

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

☐ d. Processing error OR overpayment (explain why)

☐ e. Paid to wrong provider

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

☐ g. Other

Contact Name _____ Phone _____

DMS Approved: March 6, 2020

5.9 Return to Provider Letter

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

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

- Provider ID
- Member identification number
- Member first and last names
- EOMB for Medicare/Medicaid crossover claims

Other reasons for return may include:

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

gainwell

RETURN TO PROVIDER LETTER

Date: _____-_____-_____

Dear Provider,

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

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

02) _____ Provider Signature

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

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

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

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

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

_____ Missing _____Invalid

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

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

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

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

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

_____

_____

_____

_____ Claim(s) are being returned to you for correction for the reasons noted above.

Helpful Hints When Billing for Services Provided to a Medicaid Member

- The Member's Medicaid number on the CMS must be entered in Field 1A
- The Member's Medicaid number on the UB04 must be entered in Block 60
- Member Medicare numbers **are not** valid Medicaid numbers
- Please refer to your billing manual if you have any concerns about billing the Medicaid program correctly.

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Provider Relations Group, Monday through Friday, 8:00 am until 6:00 pm eastern standard/daylight savings time, at 800-807-1232. **Electronic billing is strongly encouraged. You now have the capability to submit attachments electronically. If you are interested in billing Medicaid electronically, please contact Gainwell Technologies at 1-800-205-4696 7:30 AM to 6:00 PM Monday through Friday except holidays or view our training video on www.kymmis.com under Provider Relations, Training Videos.**

Clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Contacts and Assigned Counties

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	DAVIESS	LEE	SCOTT
CRITTENDEN	LIVINGSTON	TRIGG	ELLIOTT	LEWIS	SHELBY
CUMBERLAND	LOGAN	UNION	ESTILL	MADISON	SPENCER
EDMONSON	LYON	WARREN	FAYETTE	MAGOFFIN	TRIMBLE
FLOYD	MARION	WAYNE	FLEMING	MARTIN	WASHINGTON
FULTON	MARSHALL	WEBSTER	FRANKLIN	MASON	WOLFE
GRAVES	MCCRACKEN	WHITLEY	GALLATIN	MEADE	WOODFORD

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

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

6 Completion of UB-04 Claim Form with NPI

The Uniform Billing form (UB-04) is used to bill Hospice services rendered to eligible KY Medicaid Program Recipients. In the case of electronic billing, the information should be in an 837 Institutional format.

A completed UB-04 paper copy is located on the next page.

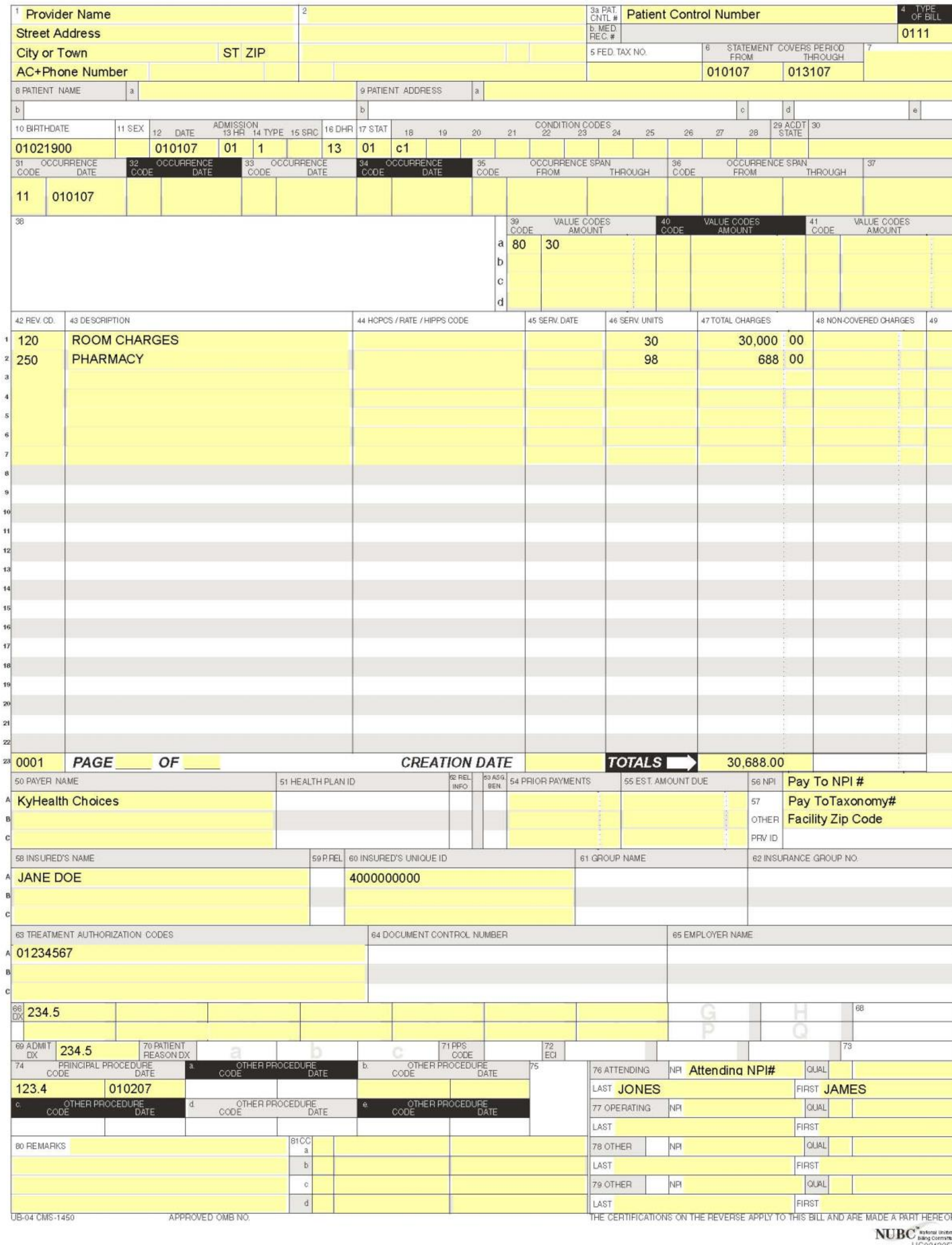
UB-04 billing forms may be obtained from the address or telephone number listed below:

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

IMPORTANT: The member's KY Medical member identification card should be carefully checked to see that the member's name appears on the card. The card is valid for the period of time in which the medical services are to be rendered. Providers cannot be paid for services rendered to an ineligible person.

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

6.1 UB-04 Claim Form with NPI and Taxonomy


1 Provider Name
Street Address
City or Town ST ZIP
AC+Phone Number
3a PAT. CNTL # Patient Control Number
b. MED. REC. #
4 TYPE OF BILL 0111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010107 THROUGH 013107
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE 01021900
11 SEX
ADMISSION 12 DATE 010107 13 HR 01 14 TYPE 1 15 SRC
16 DHR 13
17 STAT 01
CONDITION CODES 18 c1
31 OCCURRENCE CODE 11 DATE 010107
39 VALUE CODES CODE 80 AMOUNT 30
42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES
120 ROOM CHARGES 30 30,000 00
250 PHARMACY 98 688 00
0001 PAGE ____ OF ____ CREATION DATE TOTALS 30,688.00
50 PAYER NAME KyHealth Choices
56 NPI Pay To NPI #
57 Pay ToTaxonomy#
OTHER PRV ID Facility Zip Code
58 INSURED'S NAME JANE DOE
60 INSURED'S UNIQUE ID 4000000000
63 TREATMENT AUTHORIZATION CODES 01234567
66 DX 234.5
69 ADMIT DX 234.5
74 PRINCIPAL PROCEDURE CODE 123.4 DATE 010207
76 ATTENDING NPI Attending NPI#
LAST JONES FIRST JAMES
77 OPERATING
78 OTHER
79 OTHER
80 REMARKS
UB-04 CMS-1450
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC LIC9213257

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

6.2.1 Detailed Instructions

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

<table>
<tr><th>FIELD NUMBER</th><th>FIELD NAME AND DESCRIPTION</th></tr>
<tr><td>1</td><td>Provider Name, Address, and Telephone
Enter the complete name, address, and telephone number (including area code) of the facility.</td></tr>
<tr><td>3</td><td>Patient Control Number
Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.</td></tr>
<tr><td>4</td><td>Type of Bill
Enter the appropriate code to indicate the type of bill (TOB).
<table>
<tr><td>1st Digit</td><td>Enter zero</td></tr>
<tr><td>2nd Digit (Type of Facility)</td><td>8 = Hospice</td></tr>
<tr><td>3rd Digit (Bill Classification)</td><td>1 = Hospice (Non-Hospital Based)
2 = Hospice (Hospital Based)</td></tr>
<tr><td>4th Digit (Frequency)</td><td>1 = Admit through discharge
2 = Interim, first claim
3 = Interim, continuing claim
4 = Interim, final claim</td></tr>
</table></td></tr>
<tr><td>6</td><td>Statement Covers Period
FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).
THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).
Do not include days prior to when the member’s Hospice election period began.</td></tr>
<tr><td>10</td><td>Date of Birth
Enter the member’s date of birth.</td></tr>
<tr><td>12</td><td>Admission Date
Enter the date on which the member was admitted to the Hospice program in numeric format (MMDDYY).</td></tr>
</table>

<table>
<tr><th>FIELD NUMBER</th><th>FIELD NAME AND DESCRIPTION</th></tr>
<tr><td>17</td><td>Patient Status Code
Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the “through” date in Form Locator 6.
Status Codes Accepted by KY Medicaid
<table>
<tr><td>01</td><td>Discharged (left care of this hospice)</td></tr>
<tr><td>20</td><td>Expired</td></tr>
<tr><td>30</td><td>Still a patient of this hospice</td></tr>
<tr><td>40</td><td>Expired at Home</td></tr>
<tr><td>41</td><td>Expired in a medical facility, such as hospital, SMF, ICF, or Free Standing Hospice</td></tr>
<tr><td>42</td><td>Expired – Place Unknown</td></tr>
</table></td></tr>
<tr><td>18 – 28</td><td>Condition Codes
Peer Review Organization (PRO) Indicator
Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee.
A1= Special Program Indicator for EPSDT</td></tr>
<tr><td>31 – 34</td><td>Occurrence Codes and Dates
Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.
NOTE: Enter occurrence code 55 (Date of Death) and the member’s date of death when billing for Service Intensity Add-on (SIA).
Accident Related Codes:
01 = Auto Accident
02 = No Fault Insurance Involved – Including Accident or Other
03 = Accident – Tort Liability
04 = Accident – Employment Related
05 = Other Accident – Not described by the other codes</td></tr>
<tr><td>42</td><td>Revenue Codes
Enter the three-digit revenue code identifying specific services provided. A list of revenue codes covered by KY Medicaid is located in Appendix F of this manual.
NOTE: Revenue codes 551 and 561 may be utilized to indicate Service Intensity Add-on (SIA) billing. When billing for SIA services, a procedure code is also required.
Note: Total charge Revenue code 0001 must be the final entry in column 42, line 23.
Note: The total charge amount must be shown in column 47, line 23.</td></tr>
</table>

<table>
<tr><th>FIELD NUMBER</th><th>FIELD NAME AND DESCRIPTION</th></tr>
<tr><td>43</td><td>Description
Enter a From and Through date (within this billing period) in numeric format (MMDDYY) for each revenue code shown in field 42. Enter service dates for one calendar month only on each line, except in the case of respite care and SIA billing.
NOTE: SIA must be billed as one date of service per line (no span dating). The last 7 days of life may be billed for SIA but must be billed after the date of death occurs.</td></tr>
<tr><td>44</td><td>CPT/RATES
SIA claims require a CPT-4 procedure code to be billed in conjunction with the revenue codes below.
<table>
<tr><th>Revenue Code</th><th>Description</th><th>Procedure Code</th><th>Description</th></tr>
<tr><td>551</td><td>Assessment - RN</td><td>G0299</td><td>HHS/Hospice of RN 15 min</td></tr>
<tr><td>561</td><td>Medical Social Svs</td><td>G0155</td><td>HHCP-Svs of CSW, 15 min</td></tr>
</table></td></tr>
<tr><td>45</td><td>Creation Date
Enter the invoice date or invoice creation date.</td></tr>
<tr><td>46</td><td>Unit
Enter the quantitative measure of services provided per revenue code.
Units are measured in days for codes 155, 182, 183, 184, 185, 654, 651, 655, and 656. Units are measured in hours for code 652, and in number of prescription drugs for 250.
Units for Medicare co-payment are measured in days for 658 and in number of prescriptions for 659.
Units for SIA are to be measured in 15-minute increments for revenue codes 551 and 561. SIA units may not exceed 16 units (4 hours) per date of service.</td></tr>
<tr><td>47</td><td>Total Charges
Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry “total charges.”
The claim total must be shown in field 47, line 23.</td></tr>
<tr><td>50</td><td>Payer Identification
Enter the names of payer organizations from which the provider expects payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.*
*KY Medicaid is the payer of last resort.</td></tr>
</table>

FIELD NUMBER	FIELD NAME AND DESCRIPTION
54	**Prior Payments** Enter the amount the facility has received toward payment of the claim. Third party payment should be entered in this area.
56	**NPI** Enter the Pay To National Provider Identifier (NPI) number.
57	**Taxonomy** Enter the Pay To Taxonomy number.
57B	**Other** Enter the facility's zip code of the Pay To provider.
58	**Insured's Name** Enter the member's name in Form Locators 58 A, B, and C that relates to the KY Medicaid 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.
60	**Identification Number** Enter the member identification number in Form Locators 60 A, B, and C that relates to the member's name in Form Locators 58 A, B, and C. Enter the 10-digit member identification number exactly as it appears on the member identification card.
67	**Principal Diagnosis Code** Enter the ICD-10-CM code effective with dates of service 10/01/2015.
67A – Q	**Other Diagnosis Code** Enter the ICD-10-CM code effective with dates of service 10/01/2015.
76	**Attending Physician ID** Enter the Attending Physician NPI number.
78	**Other** Enter the NPI number of the Nursing Facility, if applicable.
79	**Other (NPI)** Enter DN (to denote referring) and additional Referring Physician NPI number, if applicable.
80	**Remarks** Enter the Attending Physician taxonomy, if applicable (paper claim submission only).

7 Completion of MAP Forms

7.1 Submitting MAP Forms

The Map 383, Map 384, and Map 397 should be submitted to:

Carewise Health, Inc.
9200 Shelbyville Road, Suite 100
Attn: Medicaid Hospice
Louisville, KY 40222

Institutional Hospice: Upload applicable MAP forms into KLOCS: MAP forms 374, 375, 376, 378, 379, and 403.

Non-Institutional Hospice: Send applicable MAP forms to the Hospice Contact Center at HospiceContactCenter@ky.gov.

7.2 Completion of the Other Hospitalization Statement (MAP-383)

If a hospice member is hospitalized for any condition not related to the terminal illness, an Other Hospitalization Statement (MAP-383) must be completed.

FIELD #	FIELD NAME AND DESCRIPTION
Certification of Hospitalization	
1	**Name of Facility** Enter the hospital facility name.
2	**Recipient Name** Enter the recipient name.
3	**DOB** Enter the member's date of birth.
4	**Member ID** Enter the member identification number exactly as it appears on the member identification card.
5	**SSN** Enter the social security number exactly as it appears on the social security identification card.
6	**Date of Admission** Enter the actual date of the hospital admission.
7	**Reason for Admission** Enter the reason for the hospital admission.
8	**Admission Diagnosis** Enter the diagnosis at admission.
9	**ICD-10-CM** The ICD-10-CM code for this hospitalization must be entered.
10	**Terminal Diagnosis** Enter the terminal diagnosis.
11	**ICD-10-CM** Enter the ICD-10-CM code for the member's terminal diagnosis.
12	**Medical Director Signature** The form must be signed and dated by the medical director of the hospice.
13	**Date** The form must be signed and dated by the medical director of the hospice.
Hospice Agency	

FIELD #	FIELD NAME AND DESCRIPTION
14	**Agency Name** Enter the hospice agency name.
15	**Telephone #** Enter the hospice agency telephone number.
16	**Medicaid Provider #** Enter the eight-digit KY Medicaid provider ID. The number may begin with “71” or “44”.
17	**Fax #** Enter the hospice agency fax number.
18	**Provide and/or attach documentation verifying that the hospitalization is NOT related to terminal illness.** Verification that the reason for this hospitalization is in no way related to the terminal illness is required.
19	**First time hospitalization for a condition NOT related to the terminal illness?** The appropriate block regarding previous hospitalizations must be checked.
Previous hospitalizations for conditions NOT related to terminal illness	
20	**Date** Enter the admission date of the first hospitalization NOT related to the terminal illness.
21	**Diagnosis** Enter the diagnosis of the first hospitalization NOT related to the terminal illness.
22	**Date** Enter the admission date of the second hospitalization NOT related to the terminal illness.
23	**Diagnosis** Enter the diagnosis of the second hospitalization NOT related to the terminal illness.
24	**Date** Enter the admission date of the third hospitalization NOT related to the terminal illness.
25	**Diagnosis** Enter the diagnosis of the third hospitalization NOT related to the terminal illness.
26	**Date**

FIELD #	FIELD NAME AND DESCRIPTION
	Enter the admission date of the fourth hospitalization NOT related to the terminal illness.
27	**Diagnosis** Enter the diagnosis of the fourth hospitalization NOT related to the terminal illness.
Medicaid/Reviewer	
28	**Approved by the Medicaid Program** Check this box if the hospitalization is approved by the Medicaid Program.
29	**Denied by the Medicaid Program** Check this box if the hospitalization is denied by the Medicaid Program.
30	**Medicaid/Reviewer Signature/Title** The Medicaid representative or Reviewer's signature and title is required. A facsimile signature is not acceptable.
31	**Date** The form must be dated by the Medicaid representative or Reviewer.

The form shall be sent to the Carewise Health, Inc. for review along with the recipient's present condition. After review by the KY Medicaid Program, the form will be returned to the hospice agency marked "Approved by the KY Medicaid Program" or "Denied by the KY Medicaid Program" and signed by a KY Medicaid representative.

If approved, one copy must be sent to the admitting hospital and one copy retained by the hospice agency. Hospice services may not be billed during periods of hospitalization. If denied, the hospice agency must bill for the service using the revenue code for General Inpatient Care.

An example of the Other Hospitalization Statement (MAP-383) with the table field numbers is found on the following page.

MAP-383
(Rev. 11/22)

HOSPICE
OTHER HOSPITALIZATION STATEMENT

CERTIFICATION OF HOSPITALIZATION

Name of Facility: 1			
Recipient Name: 2		DOB: 3	
Member ID: 4		SSN: 5	
Date of Admission: 6	Admission is **NOT** related to the terminal illness of this patient.		
Reason for Admission: 7			
Admission Diagnosis: 8		ICD10 CM 9	
Terminal Diagnosis: 10		ICD10 CM 11	

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

12 Medical Director Signature

13 Date

HOSPICE AGENCY

Agency Name: 14		Telephone #: 15	
Medicaid Provider #: 16		Fax #: 17	

Provide and/or attach documentation verifying that hospitalization is NOT related to terminal illness.

18

First time hospitalization for a condition NOT related to the terminal illness? ☐ Yes ☐ No 19

Previous hospitalizations for conditions NOT related to terminal illness			
Date: 20	Diagnosis: 21		
Date: 22	Diagnosis: 23		
Date: 24	Diagnosis: 25		
Date: 26	Diagnosis: 27		

All sections above the approval line must be complete prior to review.

☐ Approved by the Medicaid Program 28

☐ Denied by the Medicaid Program 29

30 Medicaid/Reviewer Signature/Title

31 Date

CLEAR FORM

7.3 Completion of Hospice Drug Form (MAP-384)

If a hospice member requires drugs which are not related to his/her terminal illness, a Hospice Drug Form (MAP-384) must be completed and submitted to Carewise Health, Inc. with the Election of Benefits Form (MAP-374). Instructions for completion of the form are listed below:

FIELD #	FIELD NAME AND DESCRIPTION
Certification of Hospitalization	
1	**Date Submitted** Enter the date submitted.
2	**Recipient Name** Enter the name of the recipient.
3	**SSN** Enter the social security number exactly as it appears on the social security identification card.
4	**Member ID** Enter the member identification number exactly as it appears on the member identification card.
5	**DOB** Enter the member's date of birth.
6	**Date Medicaid Hospice Coverage Began** Enter the date Medicaid hospice coverage began.
7	**Terminal Diagnosis** Enter the terminal diagnosis for the member.
8	**ICD-10-CM** Enter the ICD-10-CM code.
9	**Did recipient require these medication(s) prior to Hospice admission and diagnosis of the terminal illness?** Mark Yes or No.
List the diagnosis for requested medication(s) which are NOT related to the terminal illness	
10	**Diagnosis** Enter the diagnosis for the requested medication(s) that is not related to the terminal illness.
11	**ICD-10-CM** Enter the ICD-10-CM code.

FIELD #	FIELD NAME AND DESCRIPTION
List the medication(s) NOT related to the terminal illness.	
12	**Drug/Dose/Frequency** Enter the drug name, dose, and frequency of the requested medication.
13	**Start Date** Enter the start date of the medication.
14	**End Date** Enter the end date of the medication.
15	**NDC** Enter the National Drug Code (NDC) for the prescription drug.
16	**Units** Enter the number of units required.
17	**Price Per Unit** Enter the actual price per unit.
18	**Dispensing Fee** Enter the dispensing fee.
19	**Total Charge** Enter the total charge for this prescription.
20	**Maximum Allowance** Leave blank.
Medication(s) related to hospitalization which is NOT related to the terminal illness.	
21	**Admission Date** Enter the admission date to the hospital.
22	**Discharge Date** Enter the discharge date from the hospital.
23	**Name of Hospital** Enter the name of the hospital facility.
24	**Prescribing Physician** Enter the name of the physician prescribing these drugs.
25	**Medication** Enter the name of the medication.
Provider Certification and Signature	
26	**Signature**

FIELD #	FIELD NAME AND DESCRIPTION
	The original provider's signature or the signature of the provider's authorized agent is required. A facsimile signature is not acceptable.
27	**Date** Enter the date on which this invoice was signed and submitted to KY Medicaid.
Provider Information	
28	**Name** Enter the name of the hospice agency.
29	**Telephone #** Enter the telephone number of the hospice agency.
30	**Fax #** Enter the fax number of the hospice agency.
31	**Address** Enter the address of the hospice agency.
32	**Medicaid Provider #** Enter the eight-digit KY Medicaid provider ID. The number may begin with "71" or "44".

Both copies of the MAP-384 must be attached to the Election of Benefits Form (MAP-374). Documentation must also be attached that verifies the need for the listed prescriptions/items is not related to the member's terminal illness.

One copy will be returned to the provider by Carewise Health, Inc. with the allowable maximum KY Medicaid payment entered in Block 12 for each prescription. If payment is not allowed, "NA" will be entered in Block 12.

Only one copy of the MAP-384 is submitted unless the hospice benefit is revoked or unless there is a change in the prescriptions required. The initial MAP-384 should be submitted with the member's Election of Benefit Form (MAP-374).

If the hospice benefit is revoked and then reinstated, a new MAP-384 should be sent with the second or third certification period. If there is a change in the prescriptions required, a MAP-384 must be submitted. The hospice agency should retain a copy of the invoice.

The MAP-384 must also be used when requesting prior approval for additional payment for nutritional supplements required for the member. The form should be completed as for regular prescriptions with the name of the nutritional supplement entered in Block 7 and the NDC number entered in Block 8.

Documentation from the attending physician which verifies that the nutritional supplements are required for the recipient's total nutrition must be attached to the MAP-384.

An example of the MAP-384 with the table field numbers is on the following page.

MAP-384
(Rev. 11/22)

HOSPICE NON-RELATED DRUG FORM

Date submitted: 1	Recipient Name: 2		SSN: 3
Member ID: 4	DOB: 5	Date Medicaid Hospice Coverage Began: 6	
Terminal Diagnosis: 7			ICD-10 CM: 8
Did recipient require these medication(s) prior to Hospice admission and diagnosis of the terminal illness ☐ Yes ☐ No 9			
List the diagnosis for requested medication(s) which are NOT related to the terminal illness			
Diagnosis: 10			ICD-10 CM: 11

List the medication(s) NOT related to the terminal illness.

Drug/Dose/Frequency	Start Date	End Date	NDC#	Units	Price Per Unit	Dispensing Fee	Total Charge	Maximum Allowance
12	13	14	15	16	17	18	19	20

Medication(s) related to hospitalization which is NOT related to the terminal illness.

Admission Date	Discharge Date	Name of Hospital	Prescribing Physician	Medication
21	22	23	24	25

PROVIDER CERTIFICATION AND SIGNATURE

This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient. DOCUMENTATION INDICATING THAT THESE PRESCRIPTIONS ARE NOT RELATED TO THE PATIENTS TERMINIAL ILLNESS MUST BE ATTACHED.

26 _____ Signature

27 _____ Date

PROVIDER INFORMATION

Name: 28	Telephone #: 29	Fax#: 30
Address: 31	Medicaid Provider #: 32	

CLEAR FORM

7.4 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:

FIELD NUMBER	FIELD DESCRIPTION
1	The name of the agency providing the service, the name and member identification number of the member, and the date of service must be entered in the appropriate spaces.
2	The ICD-10-CM code for the diagnosis must be entered.
3	The ICD-10-CM 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 recipient must be attached to the form.
8	All copies of the form must be submitted to: Carewise Health, Inc. 9200 Shelbyville Road, Suite 100 Attn: Medicaid Hospice Louisville, KY 40222 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.

An example of MAP-397 is on the following page.

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

8 Appendix A – Internal Control Number

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

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

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

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

9 Appendix B – Remittance Advice

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

9.1 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. **Note:** It is imperative the provider maintains any A/R page with an outstanding balance.
Summary	This section details all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice is defined in this section.
EOB Code Descriptions	EOB codes which appear in the RA are defined in this section.

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

9.2 Title

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

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

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

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

9.3 Banner Page

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

REPORT: CRA-BANN-R
RA#: 99999999

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

DATE: 01/08/2021
PAGE: 1

JD PROVIDER
555 ANY STREET
CITY, KY 55555-0000

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

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

HEADER EOBS: 3001 9932

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

9.4 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 9999999999
NPI ID 9999999999
CHECK/EFT NUMBER E99999999
ISSUE DATE 01/08/2021

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

HEADER EOBS: 1784

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

9.5 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-- / --PATIENT NUMBER--	ATTEND PROV.	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JOHN DOE			MEMBER ID: 9999999999			
9999999999999	9999999999	120320	123020	345.60	0.00	0.00
99999999999999999999						

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

RELATED HISTORY - LINE	HISTORY ICN	DATE PAID
1	9999999999999	20201211

9.6 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
9999999999999	01

CLAIMS RETURNED: 01

9.7 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.

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

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

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

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

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

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

9.8 Adjusted Claims Page

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

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

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

REPORT: CRA-TRAN-R
RA#: 99999999

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

DATE: 12/25/2020
PAGE: 157

JD PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 9999999999
NPI ID 9999999999
CHECK/EFT NUMBER E99999999
ISSUE DATE 12/25/2020

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

9.9 Financial Transaction Page

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

9.9.1 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.

9.9.2 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.

9.9.3 Accounts Receivable

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

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

All initial accounts receivable allows 60 days from the "setup date" to make payment on the accounts receivable. After 60 days, if the accounts receivable has not been satisfied nor a payment plan initiated, monies are recouped from the provider on each Remittance Advice until satisfied.

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

REPORT: CRA-SUMM-R
RA#: 99999999

COMMONWEALTH OF KENTUCKY
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 01/08/2021
PAGE: 14

JD PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 9999999999
NPI ID 9999999999
CHECK/EFT NUMBER 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.

9.10 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.

9.10.1 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

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

EXPLANATION OF REMARKS

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

EXPLANATION OF ADJUSTMENT CODE

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

EXPLANATION OF RTP CODES

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

10 Appendix C – Remittance Advice Location Codes (LOC CD)

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

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

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

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

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

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

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

12 Appendix E – Remittance Advice Status Code (ST CD)

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

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

13 Appendix F – Hospice Codes

13.1 Hospice Revenue Codes

The following is a three-character code indicating the Hospice revenue code:

Revenue Code	Description	Unit Value
651	Routine Home Care	1 Day
652	Continuous Home Care	1 Day
655	Inpatient Respite Care	1 Day
656	Short Term Inpatient Care	1 Day
155	Room and Board – SNF	1 Day
159	Room and Board – ICF/MR/DD	1 Day
183	Bed Reservation – SNF – Recipient Return to Home	1 Day
185	Bed Reservation – SNF – Recipient Hospitalization	1 Day
182	Bed Reservation – ICF/MR/DD – Recipient Return to Home	1 Day
189	Bed Reservation – ICF/MR/DD – Recipient Hospitalization	1 Day
250	Pharmacy and Nutritional Supplements	1 Prescription
551	Assessment – RN	1 unit = 15 minutes
561	Medical Social Svs	1 unit = 15 minutes

13.2 Hospice Procedure Codes

Procedure Code	Description
G0155	HHCP-Svs of CSW, 15 min
G0299	HHS/Hospice of RN 15 min

14 Appendix G – Acronyms

The following acronyms are used in this document:

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

Acronym	Description
KCHIP	Kentucky Children's Health Insurance Program
KY	Kentucky
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
PRO	Peer Review Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RTP	Return to Provider
SIA	Service Intensity Add-on
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
VREV	Voice Response Eligibility Verification