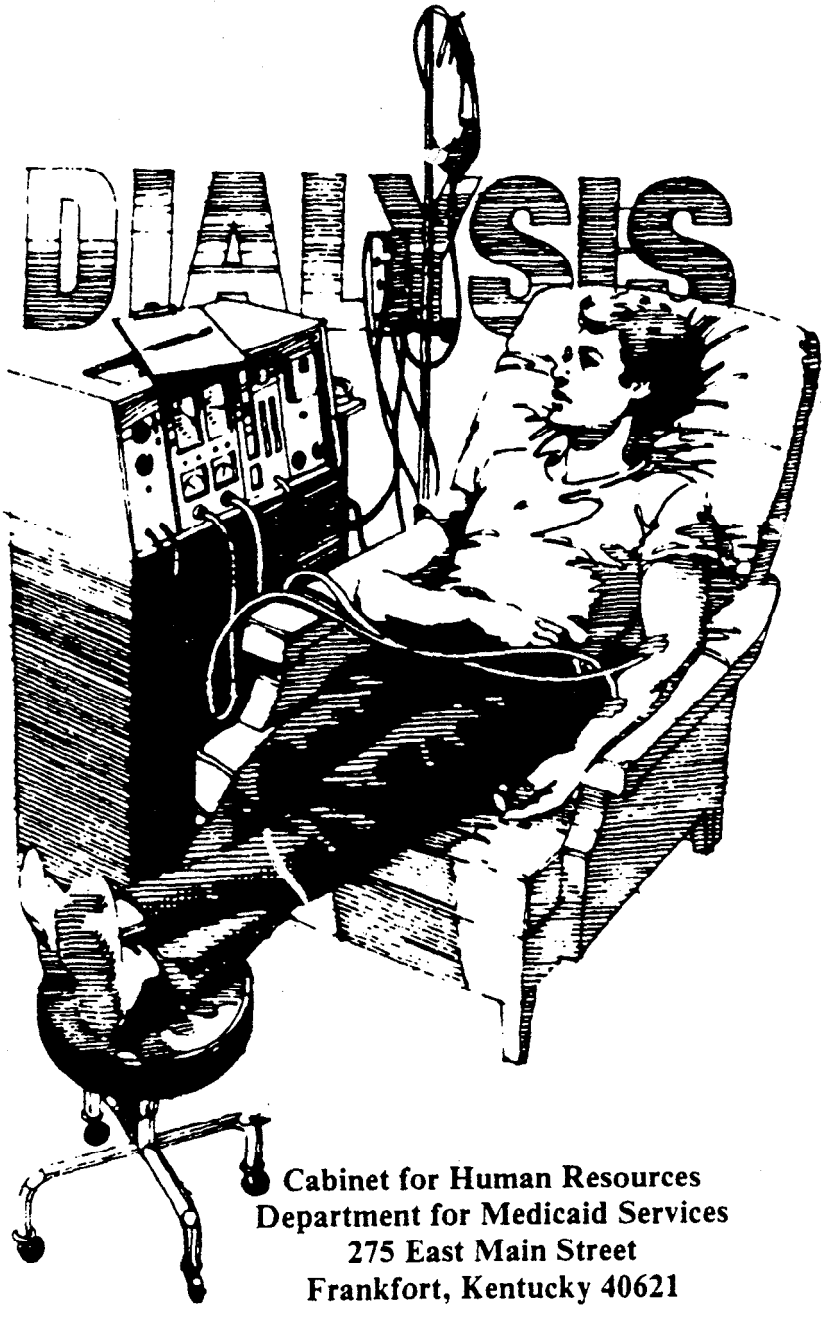
RENAL DIALYSIS CENTER SERVICES MANUAL

Kentucky Medical Assistance Program
Renal Dialysis Center Services Benefits
Policies and Procedures



Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

KENTUCKY MEDICAL ASSISTANCE PROGRAM

RENAL DIALYSIS CENTER SERVICES BENEFITS

POLICIES AND PROCEDURES

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621

TRANSMITTAL LOG FOR MANUAL UPDATES

The purpose of this log is to provide a record of changes, additions, and deletions in the KMAP Provider's Manual. As sequentially numbered transmittals are received and posted in the Provider's Manual, entry of the change number in the log is expected to provide the provider with a mechanism for eliminating errors and omissions.

TRANSMITTAL NUMBER	DATE	BY (Initials)	'RANSMITTAL NUMBER	BY (Initials)

TABLE OF CONTENTS

		Page No.
SECTION I.	INTRODUCTION	1.1-1.2
	A. Introduction	1.1
	B. Fiscal Agent	1.2
SECTION II.	KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)	2.1-2.9
	A. General	2.1
	B. Administrative Structure	2.2
	C. Advisory Council	2.2-2.3
	D. Policy	2.3-2.5
	E. Public Law 92-603 (As Amended)	2.5-2.8
	F. Timely Submission of Claims	2.9
SECTION 111.	CONDITIONS OF PARTICIPATION	3.1-3.4
	A. Appropriate Certification	3.1
	B. Out-of-State Renal Dialysis Centers	3.2
	C. Out-of-Country Rena? Dialysis Centers	3.2
	D. Termination of Participation	3.2-3.4
SECTION IV.	PROGRAM COVERAGE	4.1
SECTION V.	REIMBURSEMENT	5.1-5.2
SECTION VI.	REIMBURSEMENT IN RELATION TO MEDICARE	6.1
SECTION VI-A	REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)	6A.1-6A.5
	A. General	6A.1
	B. Identification of Third Party Resources	6A.1-6A.2
	C. Private Insurance	6A.2-6A.3
	D. Medicaid Payment for Claims Involving a Third Party Claim	6A.3-6A.4
	E. Amounts Collected from Other Sources	6A.4
	F. Accident and Work Related Claims	6A.5

TABLE OF CONTENTS

		PAGE NO.
SECTION VII.	COMPLETION OF UB-82	7.1-7.5
	A. General	
	B. Completion of UB-82	z-7.5
SECTION VIII.	REMITTANCE STATEMENT	8.1-8.5
	A. General	8.1
	B. Medicare Deductibles and Coinsurance	8.2
	C. Section I - Claims Paid	8.2-8.3
	D. Section II - Denied Claims	8.3
	E. Section III - Claims in Process	8.4
	F. Section IV - Returned Claims	8.4
	G. Section V - Claims Payment Summary	8.4-8.5
	H. Section VI - Description of Explanation Codes Listed Above	8.5
SECTION IX.	GENERAL INFORMATION - EDS	9.1-9.7
	A. Correspondence Forms Instructions	9.1-9.2
	B. Telephoned Inquiry Information	9.2
	C. Filing Limitations	9.3
	D. Provider Inquiry Form	9.4-9.5
	E. Adjustment Request Form	9.6-9.7

TABLE OF CONTENTS

RENAL DIALYSIS CENTER SERVICES APPENDIX

Appendix I - Kentucky Medical Assistance Program (KMAP) Services
Appendix II - Eligibility Information
Appendix II-A - Kentucky Medical Assistance Identification (M.A.I.D.) Card
Appendix II-B - Kentucky Medical Assistance Identification (M.A.I.D./QMB) Card
Appendix II -C Qualified Medicare Beneficiary Identification (Q.M.B.) Card
Appendix III - Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services Provider Agreement (MAP-343)
Appendix IV - Kentucky Medical Assistance Program Provider Information (MAP-344)
Appendix VI - Third Party Liability Provider Lead Form
Appendix VII - Uniform Billing Form (UB 82 HCFA-1450)
Appendix VIII - Remittance Statement
Appendix IX - Provider Inquiry Form
Appendix X - Adjustment Request Form
Appendix XI - Coding Addendum
Appendix XIII - Provider Agreement Electronic Media Addendum (MAP-380)
Appendix XIV - Agreement Between the KMAP and Electronic Media Billing Agency (MAP-246)

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

This edition of the Kentucky Medical Assistance Program Renal Dialysis Center Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medical Assistance Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.9 might be replaced by new pages 7.9 and 7.10).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy shall be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services shall be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-7759. Questions concerning billing procedures or the specific status of claims shall be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 333-2188 or (502) 227-2525.

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KKAP)

II. KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

A. General

The Kentucky Medical Assistance Program, frequently referred to as the Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medical Assistance Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. KMAP cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered, unallowable medical services.

The Kentucky Medical Assistance Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual in Section IV.

Each medical professional is given the choice of whether or not to participate in the KMAP. From those professionals who have chosen *to* participate, recipients may choose the one from whom they wish to receive their medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by KMAP in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Submission of fraudulent claims is punishable by fine or imprisonment. Stamped signatures are not acceptable.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

The provider's adherence to the application of policies in this manual is monitored through either post-payment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual remains in effect and thus the claims become subject to post-payment review by the Department.

Medical records, and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection or copying by Cabinet personnel. Such records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All *services* to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medical Assistance Program hereinafter referred to as KMAP, is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medical Assistance Program is payor of last resort. Accordingly, the provider of service shall seek reimbursement from such third party groups for medical services provided. If you, as the provider, receive payment from KMAP before knowing of the third party's liability, a refund of that payment amount shall be made to EDS, as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers sha11 provide services in compliance with federal and state statutes regardless of sex, race,creed, religion, national origin, handicap, or age.

B. Administrative Structure

The Department for Medicaid Services, Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. KMAP makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits is a responsibility of the local Department for Social Insurance offices, located in each county of the state.

C. Advisory Council

The Kentucky Medical Assistance Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of seventeen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other seven members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

All services are reviewed for recipient and provider abuse. Willful abuse by providers may result in their suspension from Program participation. Abuse by recipients may result in surveillance of the payable services they receive.

Claims will not be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, claims will not be paid for services that required, but did not have, prior authorization.

Claims will not be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and such payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

(I) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes *or* causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, *or* (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he

has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to *secure* such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit or another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(l) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount othetwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

Claims for covered services provided to eligible Title XIX recipients shall be received by KMAP within twelve (12) months from the date of service in order to be reimbursable. Claims received after that date will not be payable. This policy became effective August 23, 1979.

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months of the Medicare payment date. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than 12 months from the date of service." Received is defined in 42 CFR 445.45 (d) (5) as follows: "The date of receipt is the date the agency received the claim as indicated by its date stamp on the claim." For Kentucky, the date received is included within the Internal Control Number (ICN) which is assigned to each claim as it is received at EDS. The third through the seventh digits of the ICN (e.g. 9889043450010 = February 12, 1989) identify the year and day of receipt, in that order. The day is represented by a Julian date which counts the days of the year sequentially (January 1 = 001 through December 31 = 365/366). To consider those claims 12 months past the service date for processing, the provider shall attach documentation showing timely RECEIPT by EDS and documentation showing subsequent billing efforts. Claim copies are not acceptable documentation of timely billing. A maximum of twelve (12) months can elapse between EACH RECEIPT of the aged claim by the Program.

Claims for Title XVIII deductible and coinsurance amounts can be processed after the twelve-month time frame if they are received by KMAP within six (6) months of the Medicare disposition.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Appropriate Certification

1. Free-standing renal dialysis centers shall be licensed by the State and certified for participation under Title XVIII of Public Law 89-97 (Medicare) to be eligible to submit a Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services Provider Agreement (MAP-343, Rev. 5/86) and KMAP Provider Information (MAP-344, Rev. 8/85) to the KMAP. Free-standing renal dialysis centers participating in the KMAP are required to meet the current conditions of participation for free-standing renal dialysis centers governing participation under Title XVIII of Public Law 89-97, and amendments thereto. In those instances where higher standards are set by the KMAP, these higher standards will also apply.

   An applicant shall not bill KMAP for services provided to eligible recipients prior to the assignment by KMAP of a vendor number. The KMAP will not assign a vendor number until all forms required for the application for participation are completed by the applicant, returned to the Department for Medicaid Services and KMAP staff determine that the applicant is eligible to participate. Once an applicant is notified in writing of an assigned KMAP provider number, KMAP can be billed for covered services provided to eligible recipients.

2. Certification for participation under Title XVIII will not be required for centers providing only services not covered by Medicare.

3. Any renal dialysis center wishing to terminate its agreement shall submit their request in writing to the Office of the Commissioner, Department for Medicaid Services. Any services provided to KMAP recipients by the renal dialysis center as of the date of that center's termination shall not be reimbursed by EDS.

4. If a provider wishes to submit EMC claims, the provider should complete and sumbit a Provider Agreement Addendum (MAP-380 Rev. 11/86). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency should also complete and submit an Agreement (MAP-246 Rev. 10/86). These completed forms should be mailed directly to the Department for Medicaid Services, Provider Enrollment, 275 East Main Street, Frankfort, Kentucky 40621.

B. Out-of-State Renal Dialysis Centers

Free-standing out-of-state renal dialysis centers can automatically participate in the KMAP if they are participating in their own state's Title XIX program. They shall forward to the KMAP a completed Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services Provider Agreement (MAP-343) and KMAP Provider Information form (MAP-344), and a copy of their Title XIX reimbursement rate letter. If they do not participate in their own state's Title XIX Program, they must be certified to participate in the Title XVIII Program.

They must then forward a completed MAP-343 and MAP-344 along with a copy of their Title XVIII reimbursement rate letter. Once participation in the KMAP is established, the renal dialysis center is responsible for providing the KMAP with copies of any reimbursement rate letters that change their rate of reimbursement.

Renal dialysis centers will be required to submit additional information if requested by the Program.

C. Out-of-Country Renal Dialysis Centers

Renal dialysis centers located outside the United States and Territories cannot participate in the KMAP.

D. Termination of Participation

If a provider's participation is terminated by KMAP, services provided after the effective date of termination are *not* payable.

907.KAR 1:220 regulates the terms and conditions of provider partici-

pation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive *or* to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the *terms* and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving the notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony are submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any provider who has received notice from the Cabinet of termination, suspension, denial or nonrenewal of the provider agreement or of suspension from the Kentucky Medical Assistance Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medical Assistance Program. Adverse action taken against a provider under Medicare must be appealed through Medicare procedures.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. The KMAP will reimburse certified independent renal dialysis centers at the composite rate set by TITLE XVIII (Medicare).

B. The facility's composite rate is a comprehensive payment for all modes of infacility and home dialysis except for physicians' supervisory services and nonroutine laboratory services. This payment is subject to the normal Part B deductible and coninsurance requirements.

1. The clinic administrator shall sign an MAP-346 listing the clinic-based physicians and their license numbers.

2. Physicians shall sign individual MAP-347's authorizing payment to the clinic for their services outlined in the contract. The actual contracts shall be available for review by the KMAP. The administrators maintain responsibility for keeping the list of contractual physicians updated.

C. A covered service can be reimbursed only one time. Any duplication of payment by KMAP, whether due to erroneous billing or payment system faults, shall be refunded to KMAP.

Failure to refund a duplicate or inappropriate payment may be interpreted as fraud and abuse and prosecuted as such.

D. The KMAP requires all renal dialysis centers that participate in the Program to report ALL payments or deposits made toward a recipient's account, regardless of the source of payment. In the event that the renal dialysis center receives payment from an eligible KMAP recipient or their responsible party for covered services and items, KMAP regulations preclude payment being made by KMAP for those services and items unless documentation is received that the payment has been refunded. This policy does not apply to payments made by a recipient or their responsible party for non-covered services.

SECTION V - REIMBURSEMENT

All items or services considered by KMAP to be non-covered which were provided to Medicaid recipients during any period of a covered service can be billed to the recipient or any other responsible party. The amounts covering these items shall not be listed as an amount received from other sources.

E. A renal dialysis center may make arrangements or contract with an independent laboratory to furnish laboratory services.

1. Where a renal dialysis center obtains laboratory or other services for its inpatients under arrangements with an independent laboratory, the laboratory shall be certified to meet the CONDITIONS FOR COVERAGE OF SERVICES OF INDEPENDENT LABORATORIES governing participation under Title XVIII of Public Law 89-97. In cases where KMAP makes payment for renal dialysis center services provided to the recipient, receipt of payment by the renal dialysis center for those services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the recipient and the Program of further liability.

2. The Deficit Reduction Act of 1984 requires hospital outpatient and nonpatient laboratory services to be paid in accordance with a fee schedule developed by Medicare. Renal Dialysis Centers are reimbursed at the 60% outpatient rate.

   Neither deductible nor coinsurance will apply to either outpatient or nonpatient laboratory services paid under the fee schedule by Medicare. Payment in accordance with the fee schedule is payment in full.

SECTION IV -PROGRAM COVERAGE

IV. PROGRAM COVERAGE

A. The services which can be covered are as follows:

1. Physician services

   Routine physician services which are included in the hemodialysis composite rate.

2. Laboratory services

   Allowable non-routine laboratory services and fees are those set by Title XVIII (Medicare).

3. Hemodialysis

4. Home supplies and equipment recognized by Title XVIII composite rate reimbursement for home dialysis.

SECTION VI - REIMBURSEMENT IN RELATION TO MEDICARE

VI. REIMBURSEMENT IN RELATION TO MEDICARE

Section 301 of the Medicare Catastrophic Coverage Act of 1988 (MCCA) requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible and co-insurance amounts). Individuals who are entitled to Medicare Part A and who do not exceed federally-established income and resources standards shall be known as Qualified Medicare Beneficiaries (QMB's).

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that some individuals will have dual eligibility for QMB benefits and regular Medicaid benefits.

The reimbursable services for these dual eligibles, QMB only individuals, as well as the Medicare-Medicaid (non-QMB) eligible individual, include co-insurance and deductible amounts for all Medicare (Parts A and B) covered services or items regardless of whether the services or items are covered by Kentucky Medicaid.

The KMAP will pay Part B deductibles and coinsurance for renal services for its recipients, in accordance with Program benefits, policies, and procedures. Part B deductibles and coinsurance for professional component are payable in accordance with Program policies, procedures, and benefits. (See Section VII for billing instructions for deductible and coinsurance amounts.)

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

VI-A. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall actively participate in the identification of third party resources for payment on behalf of the recipient. At the time providers obtain Medicaid billing information from the recipient, they shall determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability by completing the TPL Lead Form and forwarding it to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attention: TPL Unit

The provider's cooperation will enable the Kentucky Medicaid Program to function more efficiently. Medicaid is the payor of last resort.

B. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medical Assistance program, all participating providers shall submit billings for medical services to a third party when the provider has prior knowledge that the third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider shall inquire if the recipient meets any of the following conditions: Is the recipient married or working? If so, inquire about possible health insurance through the recipient's or spouse's employer. If the recipient is a minor, ask about insurance the MOTHER, FATHER, OR GUARDIAN may carry on the recipient. In cases of active or retired retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder. For people over 65 or disabled, seek a MEDICARE number. Ask if the recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER,

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

ACCIDENT, OR IDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

Following is a list of the insurance codes on the MAID card:

A - Part A, Medicare.only
Part B, Medicare only
; : Both Parts A and B Medicare.
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private medical insurance
G - Champus
Health Maintenance Organization
; : Other and/or unknown
Absent Parent's insurance
I;: None
N - United Mine Workers
P - Black Lung

C. Private Insurance

If the recipient has third party resources, then the provider shall obtain payment or rejection from the third party before Medicaid can be filed. When payment is received, the provider shall indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy number(s) of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim.

Exceptions:

*If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit with the Medicaid claim a copy of the other insurance claim indicating "NO RESPONSE!' on the Medicaid claim form. Then forward a completed

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

TPL Lead Form to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from the insurance company is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider, indicating that XYZ insurance company has been contacted and an agent verified that the recipient was not covered, can also be attached to the Medicaid claim.

D. Medicaid Payment for Claims Involving a Third Party

If you have questions regarding third party payors, please contact:

EDS
Third Party Unit
P.O. Box 2009
Frankfort, KY 40602

(800) 333-2188
or
(502) 227-2525

Claims meeting the requirements for KMAP payment will be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party will be applied to any non-covered days or services and any remaining monies will be deducted from the KMAP payment. If the third party payment amount exceeds the Medicaid allowed amount, the resulting KMAP payment will be zero. Recipients cannot be billed for any difference in covered charges and the Medicaid payment amount. Providers shall accept Medicaid payment as payment in full.

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider shall pursue payment with this third party resource before billing Medicaid again.

Itemized statements shall be stamped "Medicaid Assigned" when they are forwarded to insurance companies, attorneys, recipients, etc.

E. Amounts Collected from Other Sources

1. If subsequent to billing KMAP, a provider receives monies for a service which, when added to KMAP's payment and all other payments for the service, creates an excess over the defined maximums, then that excess amount shall be refunded to KMAP up to the total amount paid by KMAP. Refund checks should be made payable to the "Kentucky State Treasurer" and mailed directly to: EDS, P.O. Box 2009, Frankfort, KY 40602, Attn: Cash/Finance

2. . When verification exists that the recipient has received monies from a liable third party for services paid by KMAP, the provider shall refund the full amount paid by KMAP and may seek total charges from the recipient. If the recipient did not receive enough monies to cover the total service, the provider may rebill KMAP, showing all amounts received from other sources.

3. As a result of the passage of recent legislation, any time a Medicaid recipient requests an itemized bill and KMAP has made payment or has been billed for payment, the hospital shall release the bill. Each page shall be stamped indicating that the bill is for informational purposes only. In addition, the hospital shall complete the TPL Lead Form and forward it to the KMAP.

4. Please refer to the reverse side of the recipient's Medical Assistance Identification Card for the recipient's assignment of benefits: "You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf."

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

F. Accident and Work Related Claims

For claims billed to KMAP that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment shall be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as the names of attorneys, other involved parties and the recipient's employer to the claim when submitting to KMAP for Medicaid payment.

SECTION VII - COMPLETION OF UB-82

VII. COMPLETION OF UB-82

A. General

The UB-82 is to be used to bill for services provided by certified free-standing renal dialysis centers to eligible Medicaid recipients Typing of the invoice form is strongly urged, since an invoice form cannot be processed unless the information supplied is complete and legible.

The original of the two-part invoice shall be submitted to EDS as soon as possible after the service is provided. The carbon copy of the invoice shall be retained by the provider as a record of claim submittal.

All UB-82 Invoices shall be sent to:

EDS
P.O. Box 2045
Frankfort, KY 40602

Under Federal Regulation (42 CFR 447.45) effective August 23, 1979, a requirement relating to timely submission of claims under Title XIX (KMAP) was added. Providers shall submit claims within twelve (12) months of the date of service.

SECTION VII - COMPLETION OF UB-82

B. Completion of UB-82

UB-82 is to be used to bill for renal dialysis services provided in a Medicaid certified free-standing renal dialysis center. Applicable supporting documents, such as Medicare remittance, shall be attached to invoices.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card shall be carefully checked to see that the recipient's name appears on the card as an eligible recipient and that the card is valid for the period of time in which the medical services are to be provided Services provided to an ineligible person are not reimbursable. An example of the card is found in the appendix.

FORM LOCATOR	DESCRIPTION
1	PROVIDER NAME, ADDRESS ANO TELEPHONE NUMBER Enter the complete name and address of the provider. The telephone number, including area code, is desired. PATIENT CONTROL NUMBER Enter the patient control number assigned by the provider. The first seven digits will appear on the remittance statement as the invoice number. TYPE OF BILL Enter the 3 digit code 721 to indicate the type of bill. MEDICAID PROVIDER NUMBER Enter the provider's 8 digit number assigned by Kentucky Medicaid.

SECTION VII - COMPLETION OF UB-82

22 STATEMENT COVERS PERIOD

Enter the "FROM and "THROUGH" date in numeric month, day, and year format. The billing period can not exceed one calendar month per claim.

50 DESCRIPTION

Enter the standard abbreviation assigned to each Revenue category. Enter the appropriate CPT-4 codes for laboratory services for Revenue Codes 30X and 31X. Enter the CPT-4 code on the right side of the dotted line.

NOTE:

CLAIMS WITH A DATE OF SERVICE PRIOR TO DECEMBER 1, 1987: USE 1985 CPT CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER DECEMBER 1, 1987 THROUGH APRIL 30, 1988: USE 1987 CPT CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER MAY 1, 1988 THROUGH MARCH 31, 1989: USE 1988 CPT CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1989 THROUGH MARCH 31, 1990: USE 1989 CPT CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1990: USE 1990 CPT CODES

52 UNITS

Enter the quantitative measure of services provided per revenue code.

53 **TOTAL CHARGES**

Enter the total charges pertaining to the related revenue codes for the billing period. The detailed amounts, by revenue codes, must equal the entry "Total Charges". Total charges must be the final entry in Form Locator 53.

57 PAYER IDENTIFICATION

Enter the names of payer organizations from which the provider expects payment or has made payment. All other liable payers, including Medicare, must be billed first.

*KMAP is Payer of last resort.

60 DEDUCTIBLE (MEDICARE CROSSOVER CLAIMS)

Enter the amount as shown on the Medicare EOMB to be applied to the recipient's deductible amount due. Attach Medicare documentation.

61 CO-INSURANCE (MEDICARE CROSSOVER CLAIMS)

Enter the amount as shown on the Medicare EOMB to be applied toward the recipient's coinsurance amount due. Attach Medicare documentation.

63 PRIOR PAYMENTS

Enter the amount the provider has received toward payment of the account prior to the billing date. Spend-down amount and third party payment shall be entered in this area. Do not enter the Medicare payment.

65 INSURED'S NAME

Enter the insured's name in 65 A, B and C that relates to the payer in 57 A, B and C. Enter the recipient's name exactly as it appears on the Medical Assistance Identification Card in last name, first name and middle initial format.

68 IDENTIFICATION NUMBER

Enter the insured's identification number in 68 A, B and C. Enter the 10 digit Medical Assistance Identification number exactly as it appears on the Medical Assistance Identification Card.

77 PRINCIPAL DIAGNOSIS CODE

Enter the ICD-9-CM, VOL 1 and 2 code describing the principal diagnosis.

78-81 OTHER DIAGNOSIS CODES

Enter the ICD-9-CM, VOL 1 and 2 codes that co-exist at the time the service is provided.

92 ATTENDING PHYSICIAN I.D.

Enter the physician's license number preceded by the state abbreviation, and followed by the physician's last name.

95 SIGNATURE

The actual signature of the provider's authorized representative is required. Stamped signatures are not accepted.

96 DATE BILL SUBMITTED

Enter the date in month, day, year numeric format that the UB-82 is completed, signed and submitted to EDS.

VIII. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS Corporation processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the KMAP with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the KMAP with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

SECTION VIII - REMITTANCE STATEMENT

B. Medicare Deductibles and Coinsurance

The explanation of payment for any MEDICARE deductibles and coinsurance will appear on a separate page from regular KMAP claims and in a slightly different format. The provider shall bill the Medicare Program for any Medicare covered services provided to recipients over 65 and other eligible persons (the disabled and the blind). The Medicare Program does not cover the patient's deductible and coinsurance amounts, but the KMAP will make payment of these amounts for KMAP eligible recipients.

C. Section I - Claims Paid

Examples of the first section of the Remittance Statement are shown in Appendix VIII. This section lists all of those claims for which payment is being made for outpatient services. On the pages immediately following are item-by-item explanations of each individual entry appearing in this section of the Remittance Statement,

EXPLANATION OF REMITTANCE STATEMENT FOR
RENAL DIALYSIS CENTER SERVICES

ITEM	
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference.
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients.
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider.
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS.

SECTION VIII - REMITTANCE STATEMENT

DATES OF SERVICE	The earliest and latest dates of service as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form.
PROFESSIONAL COMPONENT	Not applicable.
AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid program for services on the claim.
CLAIM PMT AMOUNT	The amount being paid by the Medicaid program to the provider for this claim.
EOB	For explanation of benefit code, see back page of Remittance Statement.
	OUTPATIENT
PS	Place of service code depicting the location of the service.
TS	Type of service code depicting the type of service.
PROC	The HCPCS procedure code in the line item.

D. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all those claims and indicates the EOB code explaining the reason for each claim rejection. See Appendix VIII

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.

E. Section III - Claims in Process

The third section of the Remittance Statement (Appendix VIII) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim appears in the Claims In Process section of the Remittance Statement at the time of its suspension and again at the time of the last processing cycle of the month, if the claim remains in a suspended status. At the time a final determination can be made as to claim disposition (payment or rejection), the claim will appear in Section I or II of the Remittance Statement.

F. Section IV - Returned Claims

The fourth section of the Remittance Statement (Appendix VIII) lists those claims which have been received by EDS and returned to the provider because required information was missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

G. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/ DENIED — The total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity.

AMOUNT PAID — The total payment amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity.

SECTION VIII - REMITTANCE STATEMENT

WITHHELD AMOUNT	The dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies).
NET PAY AMOUNT	The dollar amount that appears on the check.
CREDIT AMOUNT	The dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount).
NET 1099 AMOUNT	The total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds.

H. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (See Appendix VIII).

SECTION IX - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Cash/Finance Unit

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
Refund	1. Refund Check 2. Photocopy of the applicable portion 3. Reason for refund

B. Telephoned Inquiry Information

WHAT IS NEEDED?

-Provider number
-Patient's Medicaid ID number
-Date of service
-Billed amount
-Your name and telephone number

WHEN TO CALL?

-When claim is not showing on paid, pending or denied sections of the R/A within 6 weeks
-When the status of claims is needed and claims do not exceed five in number

WHERE TO CALL?

-Toll-Free number 1-800-333-2188 (within Kentucky) Local - (502) 227-2525

C. **Filing Limitations**

NEW CLAIMS -	12 months from date of service
MEDICARE/MEDICAID CROSSOVER CLAIMS	12 months from date of service
	NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
THIRD-PARTY LIABILITY CLAIMS	12 months from date of service
	NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
ADJUSTMENTS	12 months from date the paid claim appeared on the R/A

D. Provider Inquiry Form

The Provider Inquiry form can be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form shall be completed for each status request.) The Provider Inquiry form shall be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-333-2188 or 1-(502)-227-2525.

Please remit BOTH copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is NOT necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may NOT be used in lieu of KMAP claim forms, Adjustment forms, or any other document required by KMAP.

In certain cases it may be necessary to return the Inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

SECTION IX - GENERAL INFORMATION - EDS

Following **are field by** field instructions **for completing the Provider Inquiry form:**

FIELD NUMBER	INSTRUCTIONS
1	**Enter your 8-digit Kentucky Medicaid Provider Number.**
2	**Enter your Provider Name and Address**
3	**Enter the Medicaid recipient's name as it appears on the Medical Assistance** I.D. **Card**
4	**Enter the recipient's 10 digit Medical Assistance** ID **number.**
5	**Enter the billed amount of the claim on which you are inquiring.**
6	**Enter the Claim Service Date(s).**
7	If **you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Statement listing the claim,**
8	If **you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Statement for that particular claim,**
9	**Enter** your **specific inquiry.**
IO	**Enter your signature and the date of the inquiry.**

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE R/A SHALL BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

FIELD NUMBER	DESCRIPTION
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the R/A (last name first).
3	Enter the complete recipient identification number as it appears on the R/A. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

SECTION IX - GENERAL INFORMATION - EDS

FIELD NUMBER	DESCRIPTION
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the R/A.
9	Enter the R/A date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid),
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Provider Relations Unit:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

RENAL DIALYSIS CENTER MANUAL

APPENDIX

CABINET **FOR HUMAN RESOURCES**
DEPARTMENT FOR MEDICAID SERVICES

RENAL DIALYSIS CENTER SERVICES MANUAL

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

DENTAL SERVICES

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices may be covered when ordered by a physician and provided by a durable medical equipment supplier or supplier of orthotics and prosthetics. Most items require prior authorization.

FAMILY PLANNING SERVICES

Comprehensive family planning services are available to a?? eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies; and durable medical equipment, appliances and certain prosthetic devices on a preauthorited basis. Coverage for home health services is not limited by age.

HOSPITAL SERVICES

INPATIENT SERVICES

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

OUTPATIENT SERVICES

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

OUTPATIENT SERVICES (con't.)

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medical Assistance Program (KMAP) participating independent laboratories includes procedures for which the laboratory is certified under Medicare.

LONG TERM CARE FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES

The KMAP can make payment to skilled nursing facilities for:

A. Services provided to Medicaid recipients who require twenty-four (24) hour skilled nursing care or skilled services which as a practical matter can only be provided on an inpatient basis*

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day if benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

INTERMEDIATE CARE FACILITY SERVICES

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision (ICF).*

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources *(ICF/MR/DD).

*Need for the intermediate and the ICF/MR/DD levels of care must be certified by a PRO.

MENTAL HOSPITAL SERVICES

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health -mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Partial Hospitalization
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possible avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance program reimburses private practicing psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

NURSE MIDWIFE SERVICES

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug preauthorization Program.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, contact lenses, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Limited Coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

PHYSICIAN SERVICES

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

- Ova and Parasities (feces)
- Smear for Bacteria, stained
- Throat Cultures (Screening)
- Red Blood Count
- Hemoglobin
- White Blood Count
- Differential Count
- Bleeding Time
- Electrolytes
- Glucose Tolerance
- Skin Tests for:
  - Histoplasmosis
  - Tuberculosis
  - Coccidioidomycosis
  - Mumps
  - Brucella
- Bone Marrow needle biopsy
  - Staining and interpretation
- Interpretation only
- Fine needle aspiration with or without preparation of smear; superficial tissue
- Deep tissue with radiological guidance
- Evaluation of fine needle aspirate with or without preparation of smears
- Duodenal intubation and aspiration; single specimen
- Multiple specimens
- Gastric intubation and aspiration; diagnostic
- Nasal smears for eospinophils
- Sputum, obtaining specimen, aerosol induced technique
- Complete Blood Count
- Hematocrit
- Prothrombin Time
- Sedimentation Rate
- Glucose (Blood)
- Blood Urea Nitrogen (BUN)
- Uric Acid
- Thyroid Profile
- Platelet Count
- Urine Analysis
- Creatinine
- Bone Marrow spear and/or cell block; aspiration only
- Aspiration; staining and interpretation
- Aspiration and staining only

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PODIATRY SERVICES

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care center include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Renal service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

SCREENING SERVICES

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

SCREENING SERVICES (con't.)

appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmental Assessment
- Screening for Urinary Problems
- Screening for hearing and vision problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

TRANSPORTATION SERVICES

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optomertrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS

KenPAC: The Kentucky Patient Access and Care System or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his or her Medical Assistance Identification Card each time a service is received.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

AIS/MR: The Alternative Intermediate Services Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services were statewide July 1, 1987. These services are provided and arranged for by home health agencies.

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and their family in adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice care waives all rights to certain Medicaid services which are included in the hospice care scope of benefits.

TARGETED CASE MANAGEMENT SERVICES:

Comprehensive Case management services are provided to handicapped or impaired Medicaid-eligible children under age 21 who also meet the eligibility criteria of the Commission for Handicapped Children, the State's Title V Crippled Children's Agency. Recipients of all ages who have hemophilia may also qualify.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Ambulatory Surgical Center Services

Medicaid covers medically necessary services performed in ambulatory surgical centers.

Birthing Center Services

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

Dental Services

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

Family Planning Services

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

Hearing Services

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Home Health Services

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies; and durable medical equipment, appliances and certain prosthetic devices on a preauthorized basis. Coverage for home health services is not limited by age.

Hospital Services

Inpatient Services

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

Outpatient Services

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

Laboratory Services

The following laboratory tests are covered when ordered by a physician and done in a laboratory certified by the Department of Health and Human Services:

Cultures (Screening)
Blood Culture (definitive)
Stool (Ova and parasites)
Smears for Bacteria, Stained
Bilirubin
Bleeding Time
Red Blood Count
Hemoglobin
White Blood Count
Differential
Complete Blood Count
Cholesterol
Clotting Time
Hematocrit
RA Test (Latex Agglutinations)
Acid Phosphatase
Alkaline Phosphatase
Potassium
Prothrombin Time
Sedimentation Rate
Uric Acid
Stool (Occult Blood)
Pap Smear
Urine Analysis
Urine Culture
Sensitivity Testing
Pregnancy Test
CPK/Creatine
Thyroid Profile
T3
T4
Glucose Tolerance
Electrolytes
Dilantin/Phenobarbital/Drug Abuse Screen
Arthritis Profile
VDRL
Glucose (Blood)
SGOT or SGPT (Serum Transaminase)
Blood Typing
Blood Urea Nitrogen
Sodium
Any 3 or More Automated Tests
Rubella
Therapeutic Drug Monitoring
Lithium
Theophylline
Digoxin
Digitoxn

Long-Term Care Facility Services.

Skilled Nursing Facility Services

The KMAP can make payment to skilled nursing facilities for:

A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided cn an inpatient basis.*

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

Intermediate Care Facility Services

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

B. Services provided to Medicaid recipients who art mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.**

*Need for the intermediate level of care must be certified by a PRO.

**Need for the ICF/MR/DD level of care must be certified by the Department for Medicaid Services.

Mental Hospital Services

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Community Mental Health Center Services

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Partial Hospitalization
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available, Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

Nurse Anesthetist Services

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

Nurse Midwife Services

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

Pharmacy Services

Legend and non-legend drugs from the approved Medical Assistance Grug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

Pharmacy Services (Continued)

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

Physician Services

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior tc coverage of these procedures.

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, contact lenses, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office vis‘it per twelve (12) month period, per patient, per physician.

Physician Services (Continued)

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

- Ova and Parasites (feces)
- Smear for Bacteria, stained
- Throat Cultures (Screening)
- Red Blood Count
- Hemoglobin
- White Blood Count
- Differential Count
- Bleeding Time
- Electrolytes
- Glucose Tolerance
- Skin Tests for:
  - Histoplasmosis
  - Tuberculosis
  - Coccidioidomycosis
  - Mumps
  - Brucella
- Complete Blood Count
- Hematocrit
- Prothrombin Time
- Sedimentation Rate
- Glucose (Blood)
- Blood Urea Nitrogen (BUN)
- Uric Acid
- Thyroid Profile
- Platelet Count
- Urine Analysis

Fodiatry Services

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

Primary Care Services

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Renal Dialysis Center Services

Renal service benefits include renal dialysis, certain supplies and home equipment.

Rural Health Clinic Services

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

Screening Services

Through the screening service element, 'eligible recipients, age 0-thru birth rnonth of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmenta? Assessment
- Screening for Urinary Problems
- Screening for Hearing and Vision Problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

Transportation Services

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

Vision Services

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS

KenFAC: The Kentucky Patient Access and Care System, or KenFAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home-and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project currently in the Bluegrass Area Development District provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services are expected tc be available statewide by July 1, 1987. These services are provided by home health agencies.

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family ir adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice *care* waives's11 rights to certain Medicaid services which are included in the hospice care scope of benefits.

ELIGIBILITY INFORMATION

PROGRAMS

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)
AFDC Related Medical Assistance
State Supplementation of the Aged, Blind, or Disabled
Aged, Blind, or Disabled Medical Assistance
Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

ELIGIBILITY INFORMATION

MAID CARDS

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

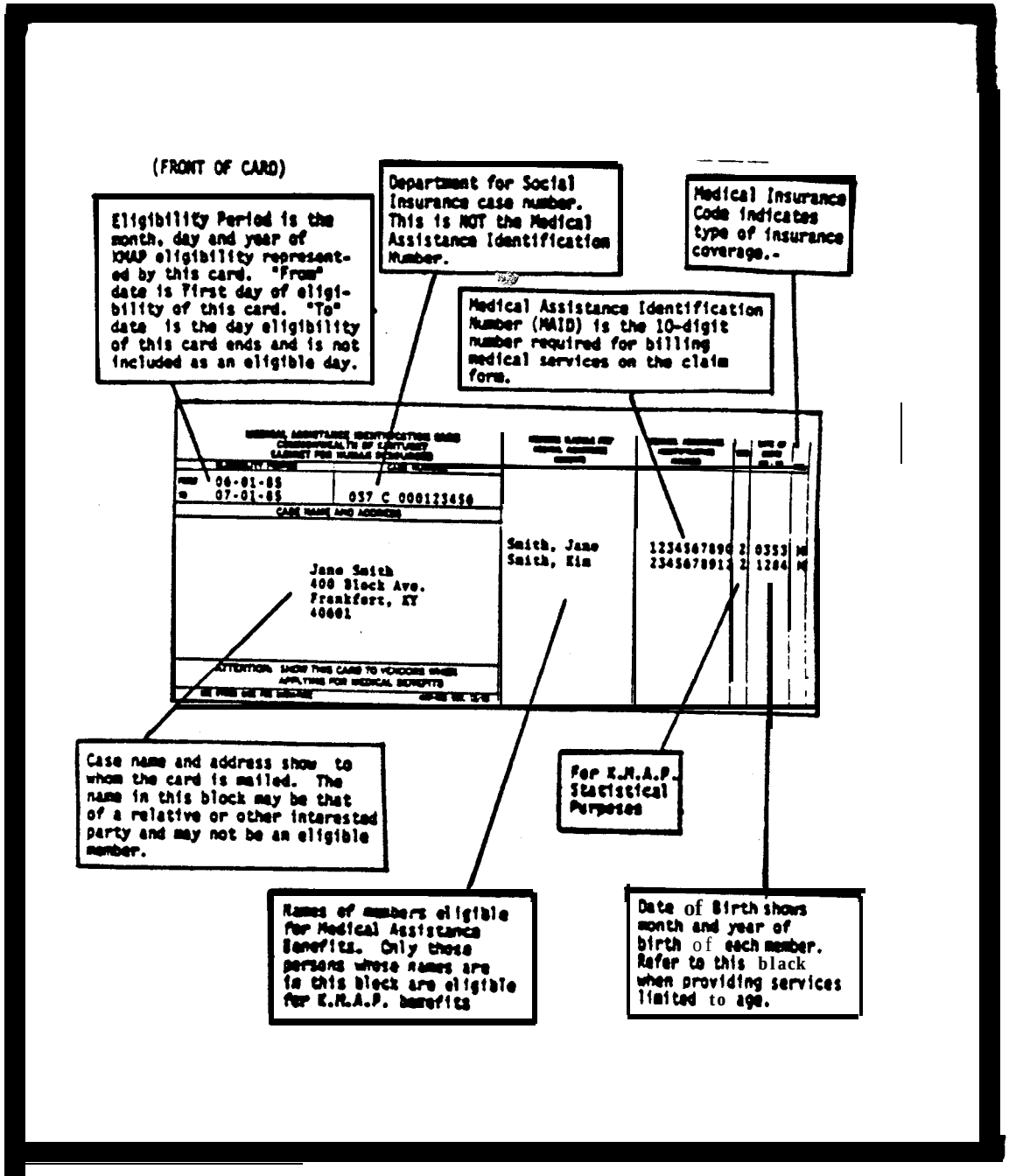
Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

VERIFYING ELIGIBILITY

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

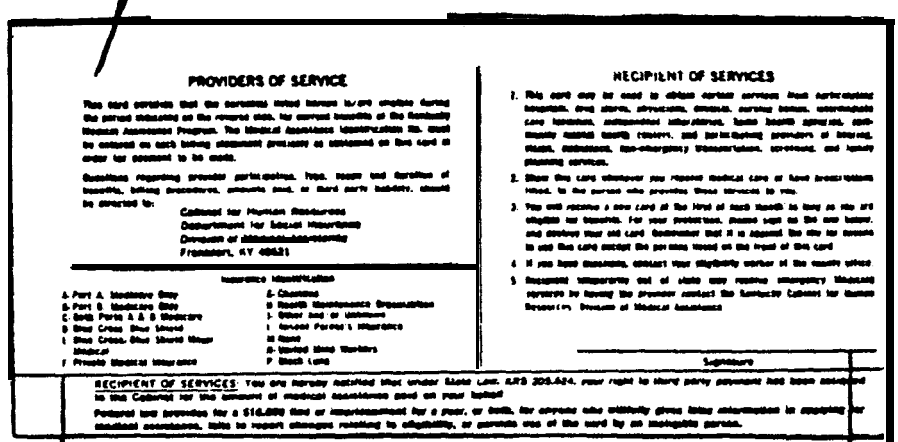


CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.



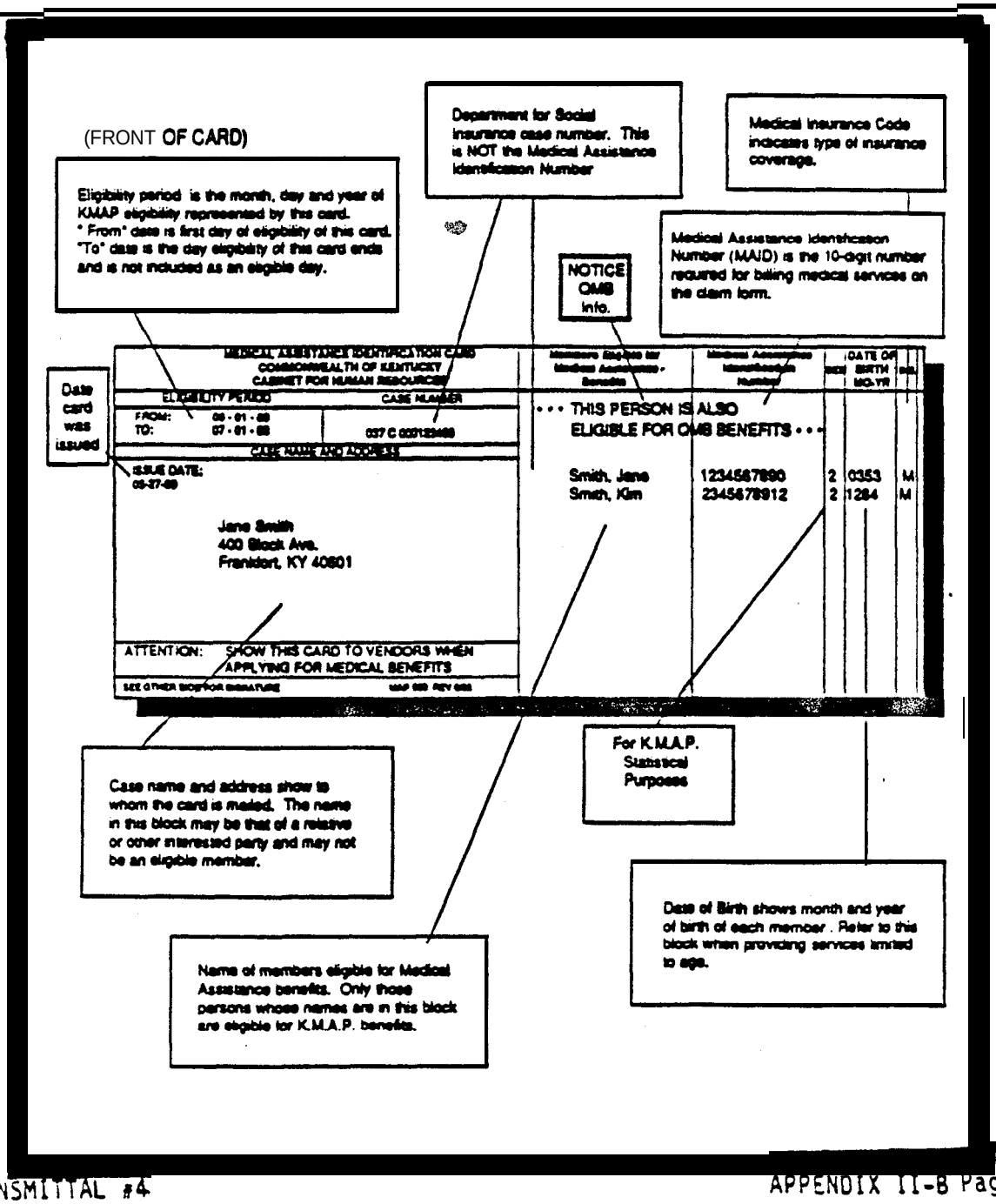
PROVIDERS OF SERVICE

RECIPIENT OF SERVICES

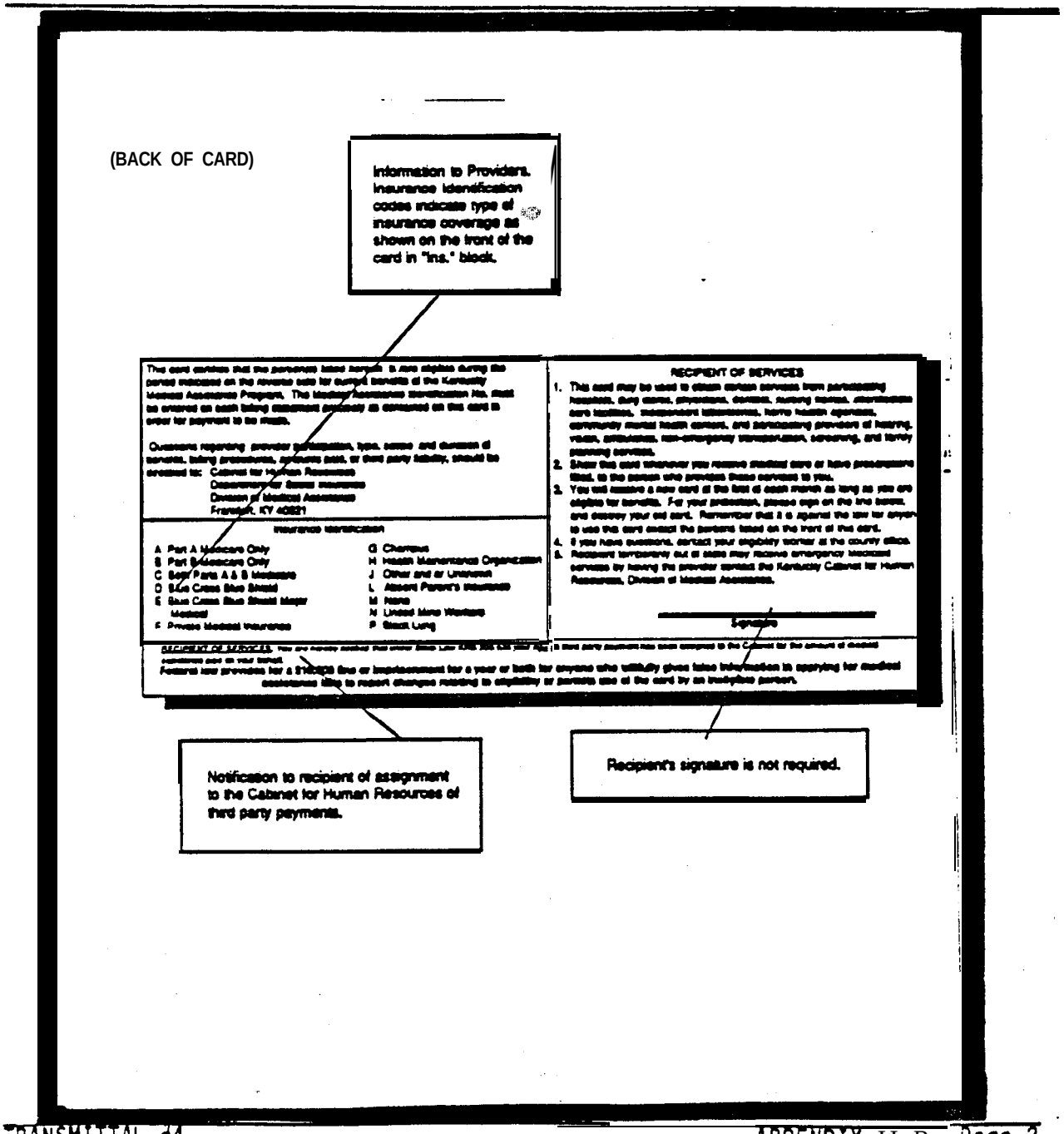
Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

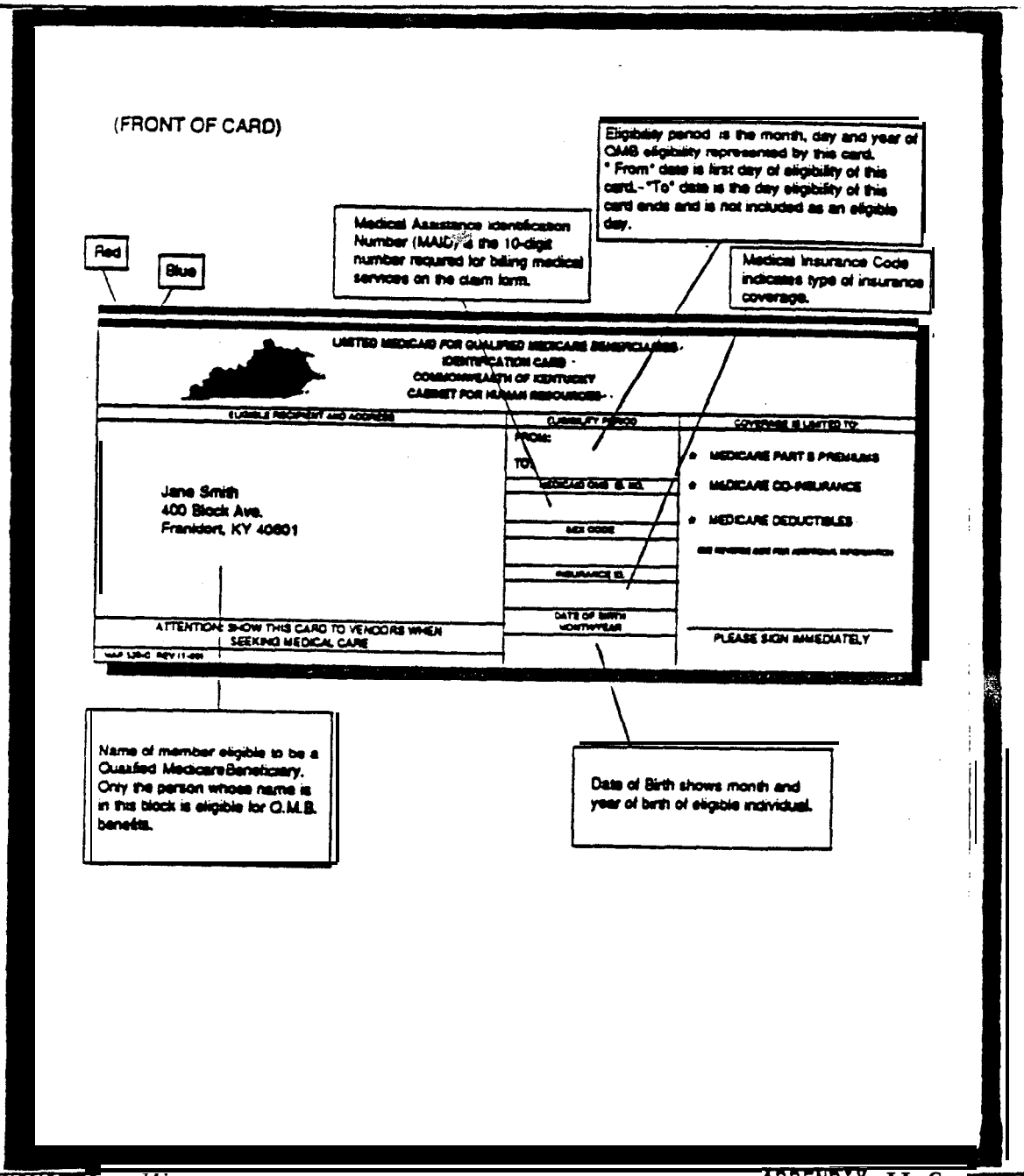
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD



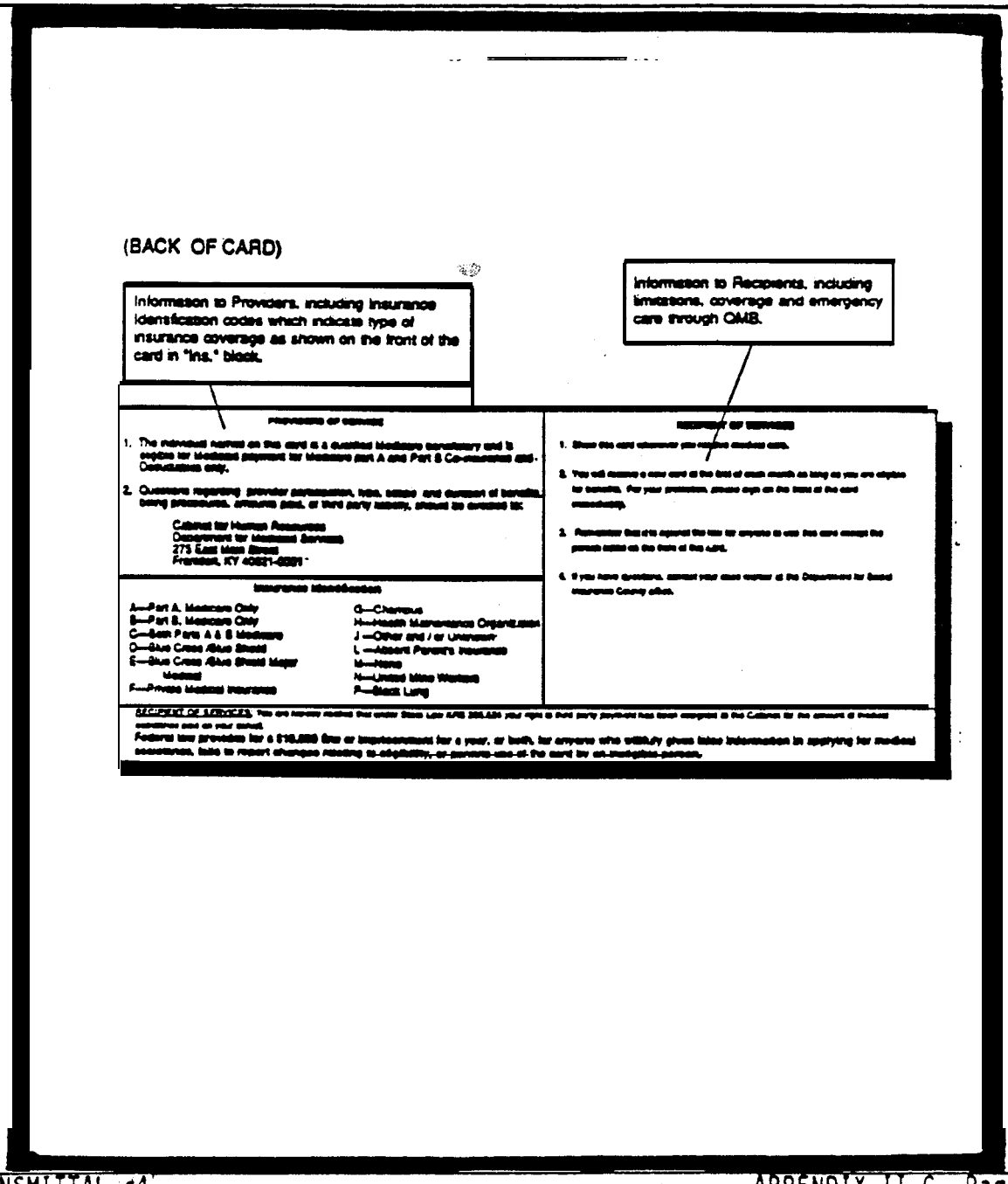
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION **(M.A.I.D./QMB) CARD**



QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD



QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD



PROVIDER AGREEMENT (MAP-343)

MAP-343 (Rev. 5/86)

Provider Number: _____
(If Known)

COMMONWEALTH Of KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ___ dry of _____, 19___, by rnd between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter Into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of Care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and State laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers dnd recipients.

(2) Certifies that he (it) Is licensed dsd _____ if applicable, under the ldn of Kentucky for the level or type of care Co which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

PROVSDER AGREEMENT (MAP-343)

MAP-343 (Rev. 5/86)

(4) Agrees to maintain such records Js are necessary to disclose the extent of services furnished to Title XIX recipients for J minimum of 5 years dnd for such additional time as may be necessary fn the event of an audit exception or other dispute dnd to furnfsh the Cabinet with Jny information requested regarding payments claimed for furnfshfng services.

(5) Agrees to permit representatives Of the state and/or federal government to have the rfght to examine, inspect, copyand/or audit all records pertaining to the provision of services furnished to Title XIX ncfpfents. (Such examinations, inspections, copying and/or audits may be nude without prior notice to the Prwfder.)

(6) Assures that he (it)is aware of Section 1909 of the Social Security Act; PublicLaw 92-603 (As Amended), reproduced on the reverse side of thfs Agreement Jnd of KRS 194.500 to 194.990 Jnd KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources. Department for Medicaid Services, within 30 days of dny change fn the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Tftle XIX recipients on the basis of marital status.

(9) (a)In the event that the Provfder is J soecialty hospital providing services to persons aged 65 dnd over, home health agency, or d skilled nursing facflfty, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is J specialty hospital prwfdfng psychiatric services to persons age 21 Jnd under, the Provider Shdll be approved by the Joint Commission on Accreditdtfon Of Hospitals. In the event that the Provider is J genera) hospital, the Provider Shall be Certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate fn the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed Dhysfcfdn or dentist of d Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation And does hereby dgre? to abide by allrules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees. subject to the availability of federal and State funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment Shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

-2-

PROVIDER AGREEMENT (MAP-343)

MAP-343 (Rev. 5/86)

3. Either party shall have the right to tcnindte this agreement at any time upon 30 days' written notice served upon the ocher pdrty by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, mdy terminate this agreement immediately far cause, or in accordance with federal regulations, upon written notice sewed upon the Provider by registered or certified mail with return receipt requested.

4. In the event of d change of ownership of dn SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____. 19___, dnd Shdll automatically terminate on _____, 19___, unless the fdcflity is recertified in accordance with applicable regulations and policies.

PROVIDER	CABINET FOR HUMAN RESOURCES DEPARTMENT FOR MEDICAID SERVICES
BY: _____ Signature of Authorized Official	BY: _____ Signature Of Authorized Official
NAME: _____	NAME: _____
TITLE: _____	TITLE: _____
OATE: _____	DATE: _____

PROVIDER AGREEMENT (MAP-343)

P.L. 92-603 LAWS OF 92nd CONG.--2nd SESS. (As Amended)

PENALTIES

Section 1909. (a) Whoever--
(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or
(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--
(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--
(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and
(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--
(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or
(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient --
(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
(B) as a requirement for the patient's continued stay in such a facility,
when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,
shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____

2. _____
Street Address, P.O.Box, Route Number (In Care of. Attention, etc.)

3. _____ _____ _____
City State Zip Code

4. _____
Area Code Telephone Number

5. _____
Payto, in Care of, Attention, etc. (If different from above)

6. _____
Pay to Address (If different from above)

7. Federal Employer ID Number: _____

a. Social Security Number: _____

9. License Number: _____

10. Licensing Board (If Applicable): _____

11. Original License Date: _____

12. KMAP Provider Number (If Known): _____

13. kdicare Provider Number (If Applicable): _____

14. Provider Type of Practice Organization:

/_/ Corporation (Public) /_/ Individual Practice /_/ Hospital-Based Physician

/_/ Corporation (Private) /_/ Partnership /_/ Group Practice

/_/ Health Maintenance Organization /_/ Profit /_/ Non-Profit

15. If group practice, Number of Providers in Group (specify provider type):

_____

-1-

PROVIDER INFORMATION (MAP-344)

PAP-344 (Rev. 08/85)

16. If corporation, name, address and telephone number of Home Office:

Name: _____

Address: _____

_____

Telephone Number: _____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership. name and address of Partners:

_____

_____

_____

_____

_____

18. National Pharmacy Number (If Applicable): _____
(Seven-Digit Number Assigned by National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

-2-

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

21. Physician/Professional Specialty Certification Board:

1st _____ Date: _____

2nd _____ Date: _____

3rd _____ Date: _____

22. Name of Clinic(s) in Which Provider is d Member:

1st _____

2nd _____

3rd _____

4th _____

23. Control of Medical Facility:

☐ Federdl ☐ State ☐ County ☐ City ☐ Charitable or Religious

☐ Proprietary (Prlvdttly owned) ☐ Other _____

24. Fiscal Yttr End: _____

25. Wmfnfstrdtor: _____ Telephone No. _____

26. Assistant Administrator: _____ Telephone No. _____

27. Controller: _____ Telephone No. _____

20. Independent Accountant or CPA: _____ Telephone No. _____

29. If sole proprittorshfp, name, address, dnd telephone number of owner:

Name: _____

Address: _____

Telephone No. _____

30. If facility is government owned, list names dnd addresses of board members:

	Name	Address
President or Chairman of Board:		
Member:		
Member:		
Member:		
Member:		

-3-

PROVIDER INFORMATION (MAP-344)

PAP-344 (Rev. 08/85)

31. Management Firm (If Applicable):

Name: _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Complete for all levels of care):

	Total Licensed Beds	Total Title XIX Certified Beds
Hospital Acute Care		
Hospital Psychiatric		
Hospital TB/Upper Respiratory Disease		
Skilled Nursing Facility		
Intermediate Care Facility		
ICF/MR/DD		
Personal Care Facility		

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

Name	Address	Percent of Ownership

-4-

PROVIDER INFORMATION (MAP-344)

HAP-344 (Rev.08/85)

35. **Institutional Review Committee Members (If Applicable):**

_____

_____

_____

_____

_____

36. **Providers of Transportation Services:**

No. of Ambulances in Operation:____ No. of Wheelchair Vans In Operation:_

Total No. of Employees: (Enclose list of names, ages. ● xpeffence 6 Training.)

Current Rates:

A. Basic Rate $_____ (Includes up to _____ miles.)

B. Per Mile $_____

C. Oxygen $_____

D. Extra Patient $_____

E. Other _____ $_____

37. Provider Authorized Signature: I certify, under penalty of law, thdt the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware thdt. should investigation at dny time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Frdud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me dnd my medical practice, dnd further authorize dnd request each educational institute, medical/license board or Organization to provfde all information thdt may be sought in connection with my application for participation In the Kentucky Medical Assistance Program.

Signature: _____

Name:_____

Title:_____ Date:_____

INTER-OFFICE USE ONLY

License Number Verified through_____(Enter Code)

Comments:_____

_____

Date:_____ Staff:_____

-5-

THIRD PARTY LIABILITY PROVIDER LEAD FORM

THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE:

PROVIDER NAME:_____ PROVIDER #:_____

RECIPIENT NAME:_____ MAID:_____

BIRTHDATE:_____ ADDRESS:_____

DATE OF SERVICE:_____TO_____ DATE OF ADMISSION:_____

DATE OF DISCHARGE:_____ NAME OF INS. CO.:_____

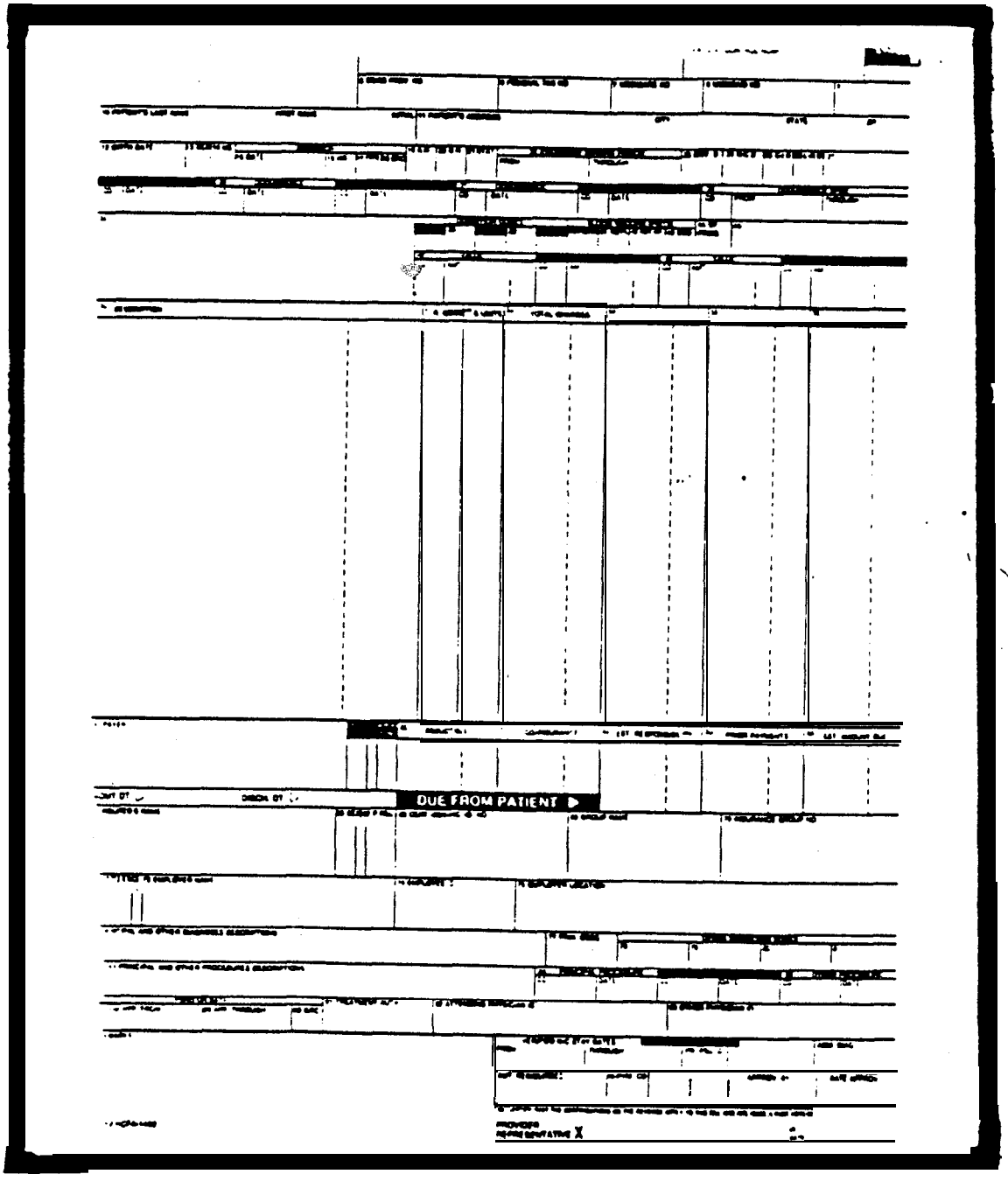
POLICY #:_____ CLAIM NO.:_____

AMOUNT OF EXPECTED BENEFITS:_____

MAIL TO: EDS Federal Corporation
Fiscal Agent for KMAP
ATTN: TPL Unit
P.O Box 2009
Frankfort, KY 40602

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

UNIFORM BILLING FORM (US-82 HCFA-1450)



REMITTANCE STATEMENT

AS OF 04/06/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 1

RA NUMBER 002543979
RA REG NUMBER 15

RENAL DIALYSIS PROVIDER
DIALYSIS CLINIC
PROVIDER NUMBER 39001234

CLAIM TYPE: PROFESSIONAL CROSSOVERS

* PAID CLAIMS *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATES	DEDUCT. AMOUNT	COINSUR. AMOUNT	CLAIM PMT. AMOUNT	EOB
4276567	ADAMS G	4061071715	9890090-805-360	011090-011090	0.00	303.06	303.06	061
01	PROC	HCD	QTY 1	011090-011090			0.00	000
MEDICARE PAID DATE	021690			MEDICARE APPROVED AMOUNT	0.00			
				MEDICARE PAID AMOUNT	0.00			
4271234	BROWN S	4005237369	9890090-805-350	011190-011190	0.00	303.06	303.06	061
01	PROC	HCD	QTY 1	011190-011190			0.00	000
MEDICARE PAID DATE	021690			MEDICARE APPROVED AMOUNT	0.00			
				MEDICARE PAID AMOUNT	0.00			

CLAIMS PAID IN THIS CATEGORY: 2 TOTAL BILLED: 606.12 TOTAL PAID 606.12

AS OF 04/06/89 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 2

RA NUMBER 002543979
RA REG NUMBER 15

RENAL DIALYSIS PROVIDER
DIALYSIS CLINIC
PROVIDER NUMBER 39001234

CLAIM TYPE: OUTPATIENT SERVICES

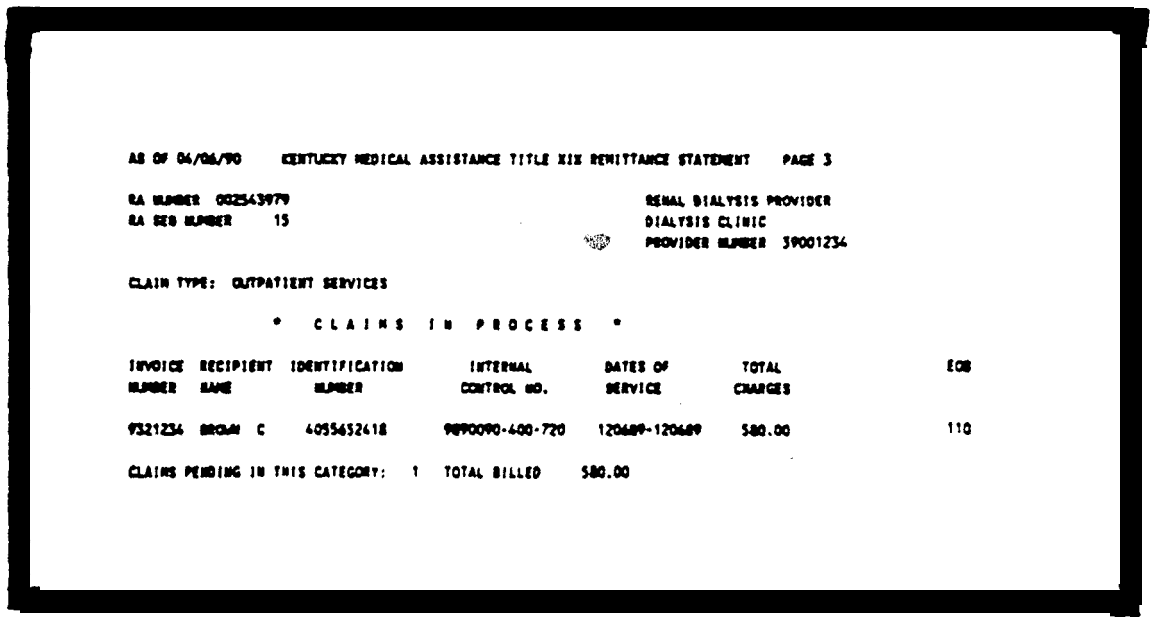
* DENIED CLAIMS *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATES	TOTAL CHARGES	EOB
4061443	COMBS S	405564053	9890090-400-300	020190-022890	1260.00	265
01	REV CODE	821	QTY 1	020190-022890	1260.00	265

CLAIM ERRORS: 00/265

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED 0.00

REMITTANCE STATEMENT



AS OF 04/06/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 3

RA NUMBER 002543979
RA SEQ NUMBER 15

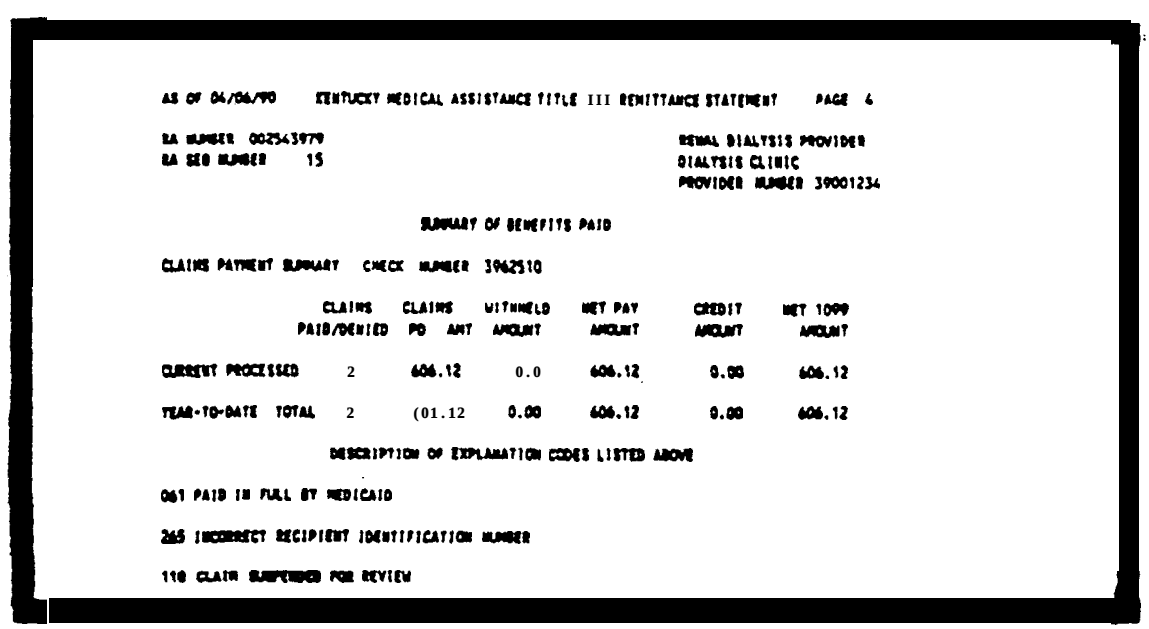
RENAL DIALYSIS PROVIDER
DIALYSIS CLINIC
PROVIDER NUMBER 39001234

CLAIM TYPE: OUTPATIENT SERVICES

* C L A I M S I N P R O C E S S *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	EOB
9321234	BROWN C	4055652418	9890090-400-720	120689-120689	580.00	110

CLAIMS PENDING IN THIS CATEGORY: 1 TOTAL BILLED 580.00



AS OF 04/06/90 KENTUCKY MEDICAL ASSISTANCE TITLE III REMITTANCE STATEMENT PAGE 4

RA NUMBER 002543979
RA SEQ NUMBER 15

RENAL DIALYSIS PROVIDER
DIALYSIS CLINIC
PROVIDER NUMBER 39001234

SUMMARY OF BENEFITS PAID

CLAIMS PAYMENT SUMMARY CHECK NUMBER 3962510

	CLAIMS PAID/DENIED	CLAIMS PD AMT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	606.12	0.0	606.12	0.00	606.12
YEAR-TO-DATE TOTAL	2	(01.12	0.00	606.12	0.00	606.12

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

061 PAID IN FULL BY MEDICAID

265 INCORRECT RECIPIENT IDENTIFICATION NUMBER

110 CLAIM SUSPENDED FOR REVIEW

PROVIDER INQUIRY FORM

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort. Ky. **40602**

Please remit bath copies of the Inquiry **Form** to EDS.

1 Provider Number

2 Provider Name and Address

3. Recipient Name (first, last)

4. Medical Assistance Number

5. Billed Amount

6. Claim Service Date

7. RA Date

8. Internal Control Number

9 Provider's Message

10. _____
Signature Date

Dear **Provider:**

_____ **This** claim has been resubmitted for possible payment.

_____ **EDS** can find no record of receipt of **this claim.** Please **resubmit.**

_____ This claim paid on _____ in the amount of _____

_____ We do not understand the nature of your **inquiry. Please** clarify.

_____ **EDS** can find no record **of receipt** of this claim **in** the last 12 months.

_____ This claim was **paid** according to Medicaid guidelines.

_____ This **claim** was **denied** on _____ for **EOB** code _____

_____ Aged **claim.** Payment may not be made for services over 12 **months** old without **proof** that the Claim was **received** by **EDS** within one year of the date of **service;** and if the claim rejects, you must show **timely receipt** by SOS **within 12** months of that **rejection** date. Claims must be **received** by EDS every **12 months** to be **considered for** payment.

Other: _____

_____
EDS Date

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

ADJUSTMENT REQUEST FORM

MAIL TO: EDS FEDERAL CORPORATION
P.O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)	EDS FEDERAL USE ONLY	
2. Recipient Name	3. Recipient Medicaid Number	
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service
	7. Billed Amt.	8. Paid Amt. / 9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature 13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

Field/Line:
New Data:
Previous Data:

Field/Line:
New Data:
Previous Data:

Other Actions/Remarks:

CABINET FOR HUMAN RESOURCES
GEPARTMENT FOR MEDICAID SERVICES

CODING ADDENDUM

REVENUE CODES ACCEPTED BY KENTUCKY MEDICAL ASSISTANCE PROGRAM

REVENUE CODE	DESCRIPTION
301	Chemistry
302	Immunology
303	Renal
304	Non/Routine Dialysis
305	Hematology
306	Bacteriology/Microbiology
307	Urology
310	Lab Pathology
311	Cytology
312	Histology
314	Biopsy
320	Radiology/Diagnostic
730	EKG/ECG Electrocardiogram
821	Hemodialysis/Outpatient or Home (Composite or other rates)
831	Peritoneal Dialysis Outpatient or home (Composite or other rate)
841	CAPD/Outpatient/Home (Composite or other rate)
920	Electromyelogram (EMG)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

PROVIDER AGREEMENT ELECTRONIC MEDIA ADDENDUM (MAP-380)

MAP-380 (Rev. 04/90)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____,
Name and Address of Provider
hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

_____ _____
(Type of Provider and/or Level of Care) (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

   "This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

PROVIDER AGREEMENT ELECTRONIC MEDIA ADDENDUM (MAP-380)

MAP-380 (Rev. 04/90)
Page 2

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER	CABINET FOR HUMAN RESOURCES Department for Medicaid Services
BY: _____ Signature of Provider	BY: _____ Signature of Authorized Official or Designee
Contact Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____
Telephone No.: _____	
Software Vendor and/or Billing Agency: _____	
Media: _____	

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

AGREEMENT BETWEEN THE KMAP AND ELECTRONIC MEDIA BILLING AGENCY (MAP-246)

Agreement between the
Kentucky Medical Assistance Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medical Assistance Program.

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)

_____, to submit claims via electronic media for
(Provider Number)

services provided to KMAP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain a record of all claims submitted for payment for a period of at least five (5) years;

3. to submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMAP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;

2. To reimburse the provider in accordance with established Policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

_____
Date

_____
Signature, Representative of the
Department for Medicaid Services

_____
Date