

**PATIENT HEALTH SERVICES  
REPORTING AND BILLING  
PROCEDURES**

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# PATIENT AND COMMUNITY HEALTH SERVICES REPORTING AND BILLING PROCEDURES

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## OVERVIEW

Kentucky's Local Health Department Patient Services Reporting System (PSRS) is a computerized statewide information network consisting of all 120 local health departments and most of their satellite service delivery sites. These sites are connected electronically to each other and to the Department for Public Health.

The reporting system offers a complete data management system for the local health department's clinical activities. The system includes the creation of a statewide patient database accessible by the state and each county health center. This database includes information needed to meet all local, state and federal government reporting requirements. Elements of clinic management which the system supports are: automated/paperless registration; patient encounter/services; appointment scheduling; immunization history and reminder; breast and cervical cancer tracking and follow-up; WIC food instrument issuance; billing and accounts receivable; community based services; and facilitates patient management from outreach through continuum of care.

The Patient Encounter Form ([PEF](#)) is an essential part of the information system. The form collects 1) the demographic characteristics of the patients; 2) the services provided to patients; 3) the local health department staff who provide the services; 4) the billing information necessary for billing the patient, Medicaid, Medicare, insurance and other third parties; and 5) the information necessary to determine WIC certifications for food instrument issuance. A tracking system is included for certain cancer screening services. It is linked with the local health department's financial management system and the personnel system by the assignment of procedure/diagnosis codes which are unique to the Cost Centers used for budgeting and costing services. The provider number is the unique employee classification identification number which is consistent with the identifier used in the personnel system. The PEF is designed to fit into an on-line automated information network, but it can be utilized without a computer network.

The Patient Encounter Form collects data, categorizes the service information by type of visit through the use of universally accepted CPT and ICD codes and provides third party billing information. It is designed to relieve the service providers of most of the reporting burden. In most instances, the provider simply checks or enters the CPT/HDPT procedure codes, the ICD codes and his or her provider number. The computer assigns the Cost Center and the payment source, i.e., Medicaid, Medicare, patient pay, etc.

In order to use the system for patient services, security clearances are obtained. The security is controlled first for the computer site, secondly by the individual person approved to use the network and then by the particular system within the network.

The system allows local sites to enter the patient services data via CORE Bridge Software as the service occurs. On-line inquiries and reports are available at each of the remote sites, which provide immediate access to data necessary for quality patient care and management of the clinic site.

## CORE BRIDGE SECURITY CLEARANCE

In order to access CDP's on-line network (data reporting systems) using Core Bridge, a user security access code must be obtained. Each component of the network has its own unique security access. To obtain security access clearance, **the Local Health Department Director or his/her designee** must submit a signed request to the Security Officer of the Public Health Support Branch.

Send requests to: [LocalHealth.HelpDesk@ky.gov](mailto:LocalHealth.HelpDesk@ky.gov) ("Security" in the subject line)

Fax: 502-564-4057

Mailing Address: Department for Public Health  
Division of Administration and Financial Management  
275 East Main St., HS1W-B  
Frankfort, KY 40621

### CORE BRIDGE SIGN-ON PASSWORDS

Prior to signing on the Core Bridge software, all users must sign on the Department's Local Area Networks (CHSDPHNT and CHSDPHLHD), which serves the Frankfort central office and the local health departments. This additional network security sign-on forces users to change their passwords at set intervals. With this additional security in place, additional password expiration is not necessary for the Core Bridge software. Core Bridge users are required to assign a unique password. If there should be any questions regarding the Local Area Networks security, contact your local IT administrator. All questions regarding the Core Bridge software security should be directed to the Security Officer at the Division of Administration and Financial Management, at 502-564-7213 or via email at the [LocalHealth.HelpDesk@ky.gov](mailto:LocalHealth.HelpDesk@ky.gov).

### CORE BRIDGE SIGN-ON INSTRUCTIONS

1) With cursor in **HOME** position-

Type command: **\*\*** (*hit F12 key*)

System response: SRI PARSING STARTED.

2) With cursor in **HOME** position-

Type command: **/SIGNON,KY? ? ? ?**

(Insert your assigned 4 numbers, then *hit F12 key*)

System response: **PLEASE ENTER YOUR CURRENT PASSWORD**

3) With cursor in **HIGHLIGHTED PASSWORD** position-

Type **YOUR PASSWORD**

(NOTE: A default password will be assigned at the time your KyNumber is created. The security officer will provide to you the default password and the KyNumber assigned to you. You *must* complete the other **HIGHLIGHTED FIELDS** on the screen to assign a *unique password*. (Passwords must be five characters in length and formatted as *numeric, numeric, alpha, numeric, numeric*. e.g. 19A35. Do not use information that is obvious to others. Try not to use a password you cannot remember in the future. Do not write down your password and leave it accessible to other users.)

(Then hit F12 key)

System response: User: KY???? SIGN ON .....etc

4) With cursor in **HOME** position-

Type command: **/SRI-NDL** (hit F12 key)

System response: NDL PARSING STARTED.

At this point sign-on is complete for Core Bridge and PC is in NORMAL OPERATION MODE.

### **CORE BRIDGE CHANGE A CURRENT PASSWORD TO A NEW PASSWORD INSTRUCTIONS**

(Note: User MUST be already signed on to change their current password to a new password.)

*Passwords must be five characters in length and formatted as numeric, numeric, alpha, numeric, numeric, e.g. 19A35. Do not use information that is obvious to others. Try not to use a password you cannot remember in the future. Do not write down your password and leave it accessible to other users.*

1) With cursor in **HOME** position-

Type command: **\*\*** (hit F12 key)

System response: SRI PARSING STARTED.

2) With cursor in **HOME** position-

Type command: **/NEWPASS** (hit F12 key)

System response: Please enter existing Password:

a) With cursor in **HIGHLIGHTED existing Password** block- type your current password.

b) Tab cursor to **HIGHLIGHTED New Password 2 Times** block- type the password you wish to use in each of the blocks (hit HOME key then hit F12 key).

System response: PASSWORD UPDATED

3) With cursor in **HOME** position-

Type command: **/SRI-NDL** (hit F12 key)

System response: NDL PARSING STARTED.

At this point password has been successfully changed and PC is in NORMAL OPERATION MODE.

### **CORE BRIDGE SIGN-OFF INSTRUCTIONS**

- 1) With cursor in **HOME** position-  
Type command: **\*\*** (*hit F12 key*)  
System response: SRI PARSING STARTED.
  
- 2) With cursor in **HOME** position-  
Type command: **/SIGNOFF** (*hit F12 key*)  
System response: User: KY???? SIGNOFF .....etc
  
- 3) With cursor in **HOME** position-  
Type command: **/SRI-NDL** (*hit F12 key*)  
System response: NDL PARSING STARTED.

At this point sign-off is complete for Core Bridge.

### **MESSAGE SENDING**

**The user has the ability to send message(s) and/or data screen(s) from station to station within the statewide network. The user must know the number assigned to the station where the message is to be sent. The Public Health Support Branch Help Desk staff may be reached at station # 2168 (CDM2168).**

#### **To send a message:**

With cursor in **HOME** position-

Type command: **CDM(station#)** (*typed message.....*) (*hit F12 key*)

#### **To send a data screen:**

First user *must remove the screen's form- hit the FRM key or CTRL key followed by the Q key-*

With cursor in **HOME** position-

Type command: **CDM(station#)** (*screen.....*) (*hit F12 key*)

### **PRINTING**

#### **A) Printing From Printer Queues:**

**The user must reactivate the printer(s) each morning to open printer queues, which allows print messages (patient services reporting system: patient receipts in queue 16, immunization certificates in queue 15, etc) to print when requested during the workday.**

If printer is used for printing messages from ALL queues, key the following command:

With cursor in **HOME** position-

Type command: **MQP (printer#) 98** (*hit F12 key*)

System response: Prtr # not busy queued for: 06 07 08 09 10 11 12 13 14 15 16

OR to open printer for particular queue(s), key the following command inserting the appropriate print queue number(s):

With cursor in **HOME** position-

Type command: **MQP (printer#) (print queue#)** (hit F12 key)

System response: Prtr # not busy queued for: (whichever print queue)

**To CLOSE ALL queues:**

With cursor in **HOME** position-

Type command: **MQP (printer#) 0** (hit F12 key)

System response: Prtr# not busy queued for: (nothing)

**B) Report Printing:**

Overnight processing of data entered daily into the reporting system creates numerous reports used for audit trail purposes. These daily reports are automatically sent to a designated printer and not to a particular printer queue as mentioned above.

Each morning user(s) must check to see that ALL reports created overnight were actually printed. Occasionally reports may not print as needed overnight (interference on the data line transmission or an electrical power failure might result in a partial report being printed or maybe not printed at all).

To obtain a list of all Patient Services Reporting System (PSRS) reports created overnight:

With cursor in **HOME** position-

Type command: **QIAI (computer site#)** (hit F12 key)

System response: (List of reports, their date of creation, number of pages, etc.)

To request that a created report print:

With cursor in **HOME** position-

Type command: **QUPR (computer site#) (printer#) (report#) ALL**

(Hit F12 key) **or CDS3** (Hit F12 key) and fill in appropriate data requested on the screen.

System response: (Acknowledgement from system that report has been sent to the printer.)

*E-Reports/Datamart*

*Forms are available at [CDP](#) website*

## **PATIENT REGISTRATION**

As each patient enters for services, patient registration is completed. If the site completing the patient registration is connected to the network, the data is entered directly into the system via computer terminal as the patient is interviewed. The registration information is printed on labels to be affixed to the Registration, Authorizations, Certifications, and Consents Form (CH-5) and filed in the medical record. If the health services delivery site is not connected to the network or if the network is not operational, the Patient Registration and Income Determination Form (CH-5B) is manually completed and filed in the medical record. The data is entered upon system availability.

The registration process, logically, is the patient's entrance into the delivery system. If the health center uses the appointment system and has entered the patient's scheduled visit into the appointment system, the registration process is much simpler. Some of the patient information is collected while making the appointment, giving the system a partial record on line for the patient registration. Also, if the patient has an existing record, i.e. the patient has been served by the health department and has a record on the computer system, locating and registering the patient is easier.

The following pages include steps to find the patient record for registration. If the patient is new to the system with no appointment or patient record, instructions follow on how to build a patient master through the registration process.

## **LOCATING, BUILDING AND UPDATING THE PATIENT RECORD**

The patient ID number is the patient's social security number. The system is designed so that the patient ID number is the controlling key to the entire patient system. Since patient names have many different spellings and tend to change often it is very important that the patient's social security number is collected as soon as possible. The number and as much demographic information as possible should be obtained when the patient is making an appointment.

### **LOCATE A PATIENT BY IDENTIFICATION (ID) NUMBER**

Patient records are indexed in the system by patient ID number and by patient name. To look up a patient by ID number, enter the following command:

**PSIZ<space>30<space><Loc><space><Patient ID#><XMIT>**

The system will search the files for the patient ID number and if the ID number is found, the registration screen will be returned with certain fields of stored patient data filled in.

If the ID number is not found, a name lookup screen will be returned for the user to type in the patient's name. If the patient is on the appointment system only, when the social security number is entered the system will come back with the name lookup screen.

### **LOCATE A PATIENT BY NAME**

When the ID number is not known, the user should do a name inquiry by entering the following:  
**PSNR<space>30<space><LOC><space><PATIENT NAME><XMIT>**

When the user transmits the PSNR command, the system searches the files for the patient's name. If the name is found, the system will signal the user to receive the registration screen. If the patient's complete name is not identified, the system will automatically display the names closest to the name keyed. When the user places R in the bracket, the system automatically places the patient's name, HID/Location and today's date on the registration screen.

NOTE: If the patient's name is listed twice or more on the name listing, the user needs to go to another page on the CRT and enter the PSNR command again. The patient's complete name should be entered. When this command is transmitted, a screen will be displayed showing the patient's date of birth and ID number.

Select the patient by birthdate, place an R before the name, and the registration screen will be displayed.

### **REGISTERING PATIENTS WITH APPOINTMENT RECORDS**

If the health department is entering appointments either by provider or through the ESNM function and the patient's name does not appear on the name look-up screen after the PSNR command is used, the user must place an "A" in the bracket on the top line and transmit. The screen will be returned with a listing of names of patients who have an appointment that are not on file. If the patient's name is identified, the user should place an "R" in the bracket by the name and transmit. The registration screen will be returned with the information on the patient you obtained when making the appointment.

If a new patient had a pseudo number at the time the appointment was made and has a Social Security number upon registration, the user should override the pseudo number with the Social Security number via the Registration Screen. This is allowed on the first visit only.

### **COMPLETING THE PATIENT REGISTRATION SCREEN**

After determining if the patient has a record in the system, enter the demographic and financial information. The registration screen will be displayed to enter data. When a patient has had a previous encounter(s), or if information has been gathered for an appointment, some fields will be filled with this stored information. This data may need to be updated. If there are multiple sites within a county or district or if the service delivery site is different from the site where the user is keying the document, the alpha suffix must be entered.

NOTE: If printing labels - do not forget to queue the printer for labels.

*Since the registration information is printed on labels for the medical record and since some of the information will only be printed on the label and is not stored in the computer - it is crucial that the labels in the printer be aligned correctly. Therefore, the 299 (CDS299 (XMIT)) command should be used to test the print alignment prior to entering and printing registration labels.*

The following definitions are to be used in entering data on the standard fee schedule registration screen. The instructions are in the same order as the fields across the screen. There are seven required fields that must be completed in order to generate a PEF label. The required fields have an ® beside them in the following descriptions:

**CLIENT:** The client number is always 30 and will be filled in when screen is displayed.

**Actn (Action):**

N (NEW); C (CHANGE); D (DELETE); R (REACTIVATE)

Screen is displayed in N (New Mode) if record does not exist. If record is on file, it is displayed in C (Change) mode.

**Hid/Loc/Site:**

The first three digits represent the health department administrative unit and the last three or four identify the location where the service was provided and the medical record is maintained (see Appendices for codes). The HID/LOCATION will be filled in when the registration screen is displayed. However, the user must enter a site code when there are multiple sites within the county or district and the delivery site is different from the site where the services are being keyed.

**Patient Id:®**

If the patient's ID number is not brought forward to the screen, enter patient's identification number.

This number is the primary means of identifying and counting patients. Accurately recording the same patient number on every visit is important. The patient's ID Number is his/her Social Security or pseudo number. It is no longer the Medicaid number.

If a patient does not have a Social Security assign a pseudo number as follows:

1. The first character is the first letter of the patient's first name.
2. The second character is the first letter of the middle or maiden name. If the patient has no middle name or maiden name, record a dash (-).
3. The third character is the first letter of the last name.
4. The fourth and fifth digits consist of the numeric month of birth.
5. The sixth and seventh digits consist of the day of birth.
6. The eighth and ninth digits consist of the year of birth.

For example, if the patient's name is Mary Jane Smith, born August 5, 1950, the pseudo number would be: MJS080550.

If there are twins, triplets or quadruplets with the same initials:

- First duplicate - add 40 to day of birth.
- Second duplicate - add 50 to day of birth.
- Third duplicate - add 60 to day of birth.

EXAMPLE: If the patients are twins with the same initials, Keith Lee Roberts and Kenny Lewis Roberts, born June 30, 1960, the pseudo numbers would be:

Keith Lee = KLR063060  
Kenny Lewis = KLR067060

To assign numbers to persons with same initials and birth dates other than twins, triplets and quadruplets; add twenty to the birth month of the first duplicate and ten to the triplet, ten to the quadruplet, etc. Examples of patient number assignments for persons with same initials and birth dates other than twins, triplets and quadruplets:

<u>Patient Number</u>	<u>Name</u>	<u>Birth date</u>
RAS121570	Ronald Albert Smith	December 15, 1970
RAS321570	Robert Allen Sutherland	December 15, 1970
RAS421570	Richard Alvin Scott	December 15, 1970
RAS521570	Raymond Alan Suter	December 15, 1970

### **Medicaid #**

If the patient's Medicaid number is not brought forward to the screen, enter the patient's Medicaid number. Patients who have applied or are potentially eligible (A) for Medicaid will not have an entry in this field until the Medicaid number is assigned. Presumptively eligible Medicaid clients will be assigned a number on the day they apply (E).

### **Today's Dt® (Date):**

The system will put in today's date. You cannot enter a future date. If the visit date is different from today's date, make sure the correct date is entered in the "Serv Date" field.

### **Reason For Visit:®**

If appointments were entered through the appointment system, the reason for visit will be displayed on the screen. If there was no appointment, the user must enter the reason for visit. There must be a reason entered in order to print a PEF label.

The reason for visit item is used to determine if income determination is required. If WIC certification/re-certification is to be provided, the OM204, OM304 or OM404 must be entered in the first position. (See ["Reason for Visit Codes."](#))

**Med Rec # (Medical Record #):**

For those health departments which have numeric filing systems, the medical record number must be entered. Up to eight digits are allowed.

**Name (L,F,M)® (Last, First, Middle):**

*If patient is a Medicaid or Medicare recipient, enter name exactly as it appears on the Medicaid or Medicare card.*

Enter the patient's last name. Do not use dashes, slashes, apostrophes, commas, periods, or any other special characters/symbols. Sample entry: MCCONNELL. Up to 17 alpha characters may be used.

Enter the patient's first name. Up to 12 alpha characters may be entered. If the patient's name contains Jr., Sr., I, II, or III, these should be entered as part of the first name.

Enter the patient's middle initial. For example, Sam (no middle name) Jones, Sr., would be recorded as Jones for last name and Sam Sr in the first name field. Do not use dashes, slashes, apostrophes, commas, periods or any other special characters/symbols.

If patient has no middle initial leave blank. If patient has a health department pseudo number with a dash for the middle initial, you must enter a dash in the middle initial field.

**Household #:** Enter household number if known or it will be automatically populated from household screen.

**Birth Dt® (Date):**

Enter the patient's date of birth using the following format: Month/Day/Year  
EXAMPLE: 08271995.

**Race®:**

Check all races as self-declared by the patient. Explain that this information is collected for reporting purposes and has no effect on any eligibility.

- **W** (White) – A person having origins in any of the original peoples of Europe, Middle East, or North Africa.
- **B** (Black or African American) – A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”
- **N** (American Indian or Alaska Native) – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachments.
- **A** (Asian) – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

- **H** (Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands).

**His/Lat (Hispanic/Latino):**

Enter “Y” (yes) or “N” (no) for the patient’s self-declared ethnicity for Hispanic or Latino. Hispanic or Latino is a person of Cuban, Mexican, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”

**Sex: ®**

Enter F (Female) or M (Male)

**County: ®**

Enter the three-digit county code of patient's residence (see Appendices for codes).

**Address:**

Enter the patient's current street address, rural route or P.O. Box number. If no home contact is flagged, the address will not be stored by the computer but will print on the registration label that is being keyed today for the medical record.

**City/St/Zp:**

Enter the city, state and zip code.

**Home Contact:**

Enter “Y” if patient may be contacted at home. To clear a "Y", enter a dash. Enter “N” if patient does not wish to be contacted at home. For patients on file, the system will display what has been entered previously. Be sure to enter address and phone number information if making a change to show home contact is acceptable. If field is left blank, it defaults to “Y”.

**If Yes, Home Phone #:**

Enter the patient's area code and home phone number. If "No" is marked, the phone number will not be stored by the computer after the patient registration is printed.

**Work Phone #:**

Enter the patient's area code and work phone number. If "No" is marked, the phone number will not be stored by the computer after the registration is printed.

**If No, How To Contact:**

Enter the address, phone number or special notes of how/where the patient may be reached. An entry is required if no home contact is entered. (Not Stored)

**Emergency Contact:**

Enter the first and last name of person to be contacted in case of an emergency. (Not Stored)

**Emergency Phone #:**

Enter the area code and phone number of emergency contact. (Not Stored)

**Mthr/Pt Maiden Nm (Mother/Patient Maiden Name):**

When appropriate, enter the first and maiden name of patient's mother. (Not Stored)

**PCP (Primary Care Physician):**

Enter the name of family/primary care physician. (Not Stored)

**Medicaid@:**

Indicate Medicaid status with one of the following codes:

- (Y) Is entered for yes if the patient has a current Medicaid card or is eligible for the Breast and Cervical Cancer Treatment Program. If (Y) is marked, the patient ID # must have the ten-digit Medicaid number. If patient says they do not have a card with them – check MDID screen for eligibility.
- (N) Is entered for no if the patient does not have Medicaid, has not applied or is not potentially eligible.
- (A) Is entered if the patient has applied for Medicaid, or if the LHD staff believe the patient is eligible based on income and age, and have counseled the patient on applying.
- (M) Is entered if the patient is an infant during postpartum period (which ends on the last day of the month following the 60th day after birth) whose mother was Medicaid eligible at the time of delivery. Patient is treated as pending in the system. After completion of the sixty (60) day period with no action taken, “M” will default to “A”.
- (K) Is entered if the patient presents an insurance card that identifies them as having K-CHIP Phase III. If patient says they do not have a card with them, check MDID card.
- (E) Is entered if the patient has been determined to be presumptively eligible for Medicaid (maximum of ninety (90) days). (For pregnant women only.) If patient says they do not have card with them, check MDID card. If the eligibility period passes with no action taken, “E” will default to “A”.

Because Medicaid eligibility status changes from month to month, it must be checked each month when the first billable service is provided.

NOTE: The KY Health-Net system must be reviewed for Medicaid eligibility and type of coverage.

(See Appendices for additional MDID instructions.)

**E Beg Dt (Presumptive Eligibility Beginning Date):**

Enter eight (8) digit date (mmddyyyy) when patient received presumptive eligibility Medicaid status.

**Reg (Region):**

Enter the Medicaid Managed Care Region Number if the patient has Medicaid and his/her residence is within the Managed Care Region. Region codes are 1 through 8.

**Member #:**

Enter the assigned Medicaid Managed Care Member number (when applicable).

**KTAP:**

Enter Y or X for (Yes) or N for (No). This item applies solely to the patient.

**FoodSt (Food Stamps):**

Enter Y or X for (Yes) or N for (No). This item applies solely to the patient.

**WH (WIC Household):**

Enter Y (Yes) if the patient is a WIC applicant who lives in a household with a pregnant woman who is fully eligible or presumptively eligible for Medicaid, or with an infant who is eligible for Medicaid, or with any household member who receives KTAP, or is an infant whose mother received Medicaid at the time of delivery, and documentation is observed. See Appendices, WIC Income Eligibility Requirements, [“Adjunct Eligibility.”](#)

**Medicare:®**

Enter Y (Yes) or N (No). To change to No, enter N.

Medicare status must be on the patient record and must currently be checked on each visit.

NOTE: If the patient has a Medicaid card, and if he/she is eligible for Medicare, the Medicaid card will indicate the Medicare coverage.

**Medicare #:**

Enter the complete Medicare Number.

To erase/delete Medicare number, enter an “\*”.

**KEIS (Kentucky’s Early Intervention System):**

Enter Y (Yes) N (No) if the patient is receiving KEIS services.

**KEIS #:**

Enter the CBIS child ID number in this field.

**PP Advantage # - Enter Passport Advantage number**

**VOC:**

Enter Y if patient is transferring from another WIC agency and recertification is not due at this visit.

**Kenpac:**

Enter Y or X for (Yes) or N for (No).

**Kenpac Nm (Number): (F, M, L)**

Enter the first, middle initial and last name of KENPAC provider.

This item applies only to patients on the Kentucky Medicaid KENPAC Program. If KENPAC approval is necessary for the service reported, approval is to be obtained from the patient's KENPAC physician and that physician's name entered here. To indicate approval was given by the KENPAC physician for each service provided, it is necessary to enter the KENPAC Physician # in that field and enter a dash before the CPT codes on the Patient Encounter Form.

**Kenpac NPI #:**

Enter the KENPAC provider's NPI number when permission has been given by the provider for a KENPAC patient to receive services.

**Fin Res Nm (Financial Responsible Name):**

Enter the first, middle initial and last name of the person responsible for payment if different from patient's.

**Bill Address:**

Enter the Street/Route where billings are to be mailed if different from patient's.

**Bill City/State/Zip:**

Enter the City, State and Zip Code where billings are to be mailed if different from patient's.

**# In Hse (Household):**

Enter the number in household which is used in conjunction with income to determine fee assessment and WIC eligibility. The number entered here is defined in the Appendices. An entry is required for this item on each initial visit to the health department and every 6 months thereafter if the visit includes services requiring income assessment.

NOTE: Income determination is required at each WIC certification visit. (See Appendices for [“WIC Income Eligibility Requirements.”](#))

**Incm (Income):**

Enter the annual household income for the patient. For WIC certification/recertification, screen 2 must be completed if applicant is not adjunct eligible.

If the patient is not adjunct eligible, screen 2 will automatically be displayed when reason for visit is WIC certification and re-certification. Income entered on Screen 2 will update the patient's record.

If income is not required, the income field is left blank. Do not space through income field. The system will enter 99999 for unknown.

If the patient had an income on a previous visit and now has a Medicaid card, do not space through the income field or enter 99999's. The income field should be left as is. If the patient has lost Medicaid benefits since the previous visit Medicaid should be marked No and income entered here. If date assessed is within 6 months of prior determination, income is not required except for WIC certification/re-certification.

**Incm Assessd (Income Assessed):**

(Y) or (N) If income must be assessed today, and even if income is the same as last assessed, enter a "Y" in this field. If income does not need to be assessed, enter an "N" for no or the system will default to no if nothing is entered.

NOTE: For services requiring income to be assessed, this assessment must be done every 6 months except for WIC certification and re-certification. (See ["WIC Income Eligibility Requirements."](#) in the Appendices.)

**Lst Assessd Dt (Last Assessed Date):**

Last date income was updated/assessed (stored in system) will be displayed.

**Labels:**

Enter the number of labels to be printed beside the type of label desired. The number of labels to be printed must be entered in the block by the type label.

P (PEF LABEL); D (MEDICAL RECORD LABEL);

B (MAILING LABEL); L (LAB LABEL);

C (MEDICAL RECORD LABEL); R (REGISTRATION LABEL)

NOTE: If Screen 2 is completed, labels will not be printed until Screen 2 is transmitted.

**Serv Date (Service Date):**

System will enter today's date. The user may enter past date (no future date allowed) if different from today in this field located at the end of the labels.

**LEP – Limited English Proficient** = Populated from PEF entry

**\*\*\*Poverty Level = .00% \*\*\*\*:**

If the patient is in the system, the poverty level percentage will have been calculated based on the income on file and will be displayed on Screen 1 when the screen comes forward for registration.

**Percent of Pay %:**

The computer calculates and displays the percent of pay the patient is assessed based on the patient's income and the Uniform Percentage Payment Schedule.

**Spec Program:** Use drop-down menu to select special program if appropriate for patient.

**Proof: Res, Id, Mdcd, KTAP, Fdst:**

This field is to be completed for WIC only. See Appendices labeled "[WIC Income Eligibility Requirements](#)" for codes and instructions.

**Dt Privacy Policy Signed:**

This date (mmddy) is to be completed when Privacy Policy is signed by patient.

**Insr® (Insurance):**

Enter Y or X for (Yes) or N for (No). If Y or X is entered, insurance coverage information must be completed. If patient has insurance and the No Home Contact has been flagged, insurance is not to be billed, therefore 999 should be entered in the Icd field on the PEF entry screen.

**Comp (Company):**

Enter the name of insurance company.

**Insr Cd (Insurance Code):**

Enter the three-digit insurance code that has been assigned for the specific insurance company/plan. The LXII command can be used to view the insurance code file for your health department. Each local health department will have up to 899 (codes 909-999 are for CHS use only) possible codes to identify insurance company plans. This file is to be built for your health department through the **CDS351 <XMIT>** command.

**Subs Nm:**

Enter the first and last name of the subscriber.

**Subs Relation:**

Enter codes of: 1=Self 2=Spouse 3=Siblings 4=Extended Family

**Policy #:**

Enter the policy number.

**Group#:**

Enter the group number.

NOTE: If the insurance does not pay for the service provided today because it is a non-covered physician or mid-level E/M visit, enter an "S" for skip in the insurance block on the encounter screen.

**Screeener®:**

The employee class ID number of the employee completing the computer screen must be entered.

**Notes:**

Free text – available space for special notes. This information is stored on the patient record.

**Apply Vote?:**

If the patient is seeking WIC benefits and is age 18 or older, the LHD is required to ask annually at a WIC certification or when adding a WIC transfer, the following: “If you are not registered to vote where you live now, would you like to register to vote here today?” If answer is Yes - enter “Y”, if No enter “N” (Screen prompts when required.)

**Print Form:**

If you want the voter application form printed, enter X or Y.

**Scr 2 (Screen 2):**

Screen 2 will automatically come up when reason for visit is WIC certification/recertification when applicant is not adjunct eligible. Screen 2 will always be displayed if an “X” or “Y” is entered in this field. You do not have to use Screen 2 for any other income determination unless you wish to use it to calculate income when many sources of income are present in a household.

NOTE: When the registration screen is completed for a patient who is receiving service(s) which do not require income determination, or anytime Screen 2 is not requested, the system will automatically print the requested labels upon transmission of Screen 1.

If you request labels, do not forget to align and queue your printer for labels and request the encounter form label.

IMPORTANT: These labels must be affixed to the CH-5 (Patient Registrations, Authorizations, Certifications, and Consents) and the patient's signature obtained for the medical record. If income determination is required on this visit, one of the financial certification blocks must be checked when the patient's signature is obtained. If the health center is not online or the system is not operating and labels for the CH-5 cannot be printed, the CH-5B (Patient Registration and Income Determination) must be completed and the patient's signature must be included for the declaration of income.

**HH SCR – Household Screen:** Enter X or Y for household screen.

**REGISTRATION SCREEN 2**

Screen 2 is used to determine the patient's household income when patient is getting a certification or recertification and has no adjunct eligibility for WIC or when calculation of income must be done. The system will automatically display the HID/LOC/Site, patient ID number, patient name and date of birth. These fields cannot be changed on screen 2.

The instructions for entering information in each field are in the same order as the fields listed across the screen.

## **INCOME DETERMINATION**

When income determination is required, the entire patient and patient's household income is to be considered and entered by type and name of household member receiving income. See Appendices for definition of income.

### **# Household:**

Number in household will be brought forward from Screen 1. This number can be changed on this screen and if number is changed it will automatically change Screen 1 and update patient record. See Appendices for definition of household.

## **SALARIED INCOME**

### **Patient Name & Household Member:**

Enter name of patient and/or household members who work.

### **Employer Name:**

Enter employer of patient and/or household members who work.

### **Pay Period:**

Enter the pay period type if the patient or household member has worked consistently earning the amount reported for the past year. The W-Weekly amount will be multiplied by 52; the Bi-Weekly by 26; the I-Semi-Monthly by 24 and the M-Monthly by 12. If the patient/household member has worked only part of a year, the income must be manually calculated and adjusted to reflect the amount for a year and an "A" entered for annual salary. (Not Stored)

### **\$Amt:**

Enter the amount for the pay period reported. The system will compute annual income. If you have calculated and adjusted income to represent annual income and have entered "A" for time period you must enter the annual amount. (Not Stored)

### **Proof:**

Must complete for WIC certification and re-certification. Enter the code from the instruction sheet in the Appendices section for the type of proof presented for each income indicated. For "other", document the type of proof presented in the patient's chart.

### **Other Income:**

Enter the name of patient and household member(s) receiving other income; enter the type of income (see screen for list of type income, i.e., (1) KTAP, (2) SSI, etc.); enter the frequency, i.e., W (Weekly), B (Bi-Weekly), I (Semi-Monthly), M (Monthly), or A (Annually), enter the amount received; enter the code from the appendices for type of proof presented for each income indicated for WIC certification and re-certification.

The system will summarize all income entered and calculate total income for a 12 month period for annual income. If the income has been received for less than a year, enter "A", and the manually calculated amount received for the past year. (Not Stored)

**Are You Changing Income?:**

This field must be completed before Screen 2 can be transmitted. If “Y” is entered, the income will be changed/updated with what is entered on today’s visit. If “N” is entered, the income currently in the system will remain the same.

After Screen 2 has been completed, transmit and labels will print. The printer must be queued for labels.

**Use Average Income:**

Enter Y (yes) or N (no) (blank means no) if the average income for the previous 12 months was computed and entered for the household income. If yes for average income, an “A” will print on the label next to the income. See Appendices for “Household Size and Household Income” for additional information.

NOTE: Once Screen 2 has been transmitted the computer will calculate the income and update Screen 1 with income and poverty level. This information will be displayed on the status line for the user.

**LABELS**

Screen 1 should have entered the type and quantity of labels to print. Label P is the PEF label that should be placed on the Encounter Form. The PEF number is assigned by the computer and will be printed on the right side, top line of the label. In order to print out a PEF label, *the following fields must have been entered:* Reason for Visit, Medicaid, Medicare, Insurance, KTAP and Food Stamps, and Reg/Fin Screener.

NOTE: If patient is a new patient, NEW PAT will print in bottom right hand corner of P (PEF) label and if patient is established, EST PAT will print. The system calculates this information and prints it on every PEF label to alleviate errors in reporting.

NOTE: If the label printer has jammed and the computer had already assigned a PEF number and you need to print another PEF label, the first PEF number must be voided by using the CDS274 Screen.

If Screen 2 is lost during transmission, enter the registration information (PSIZ or PSNR commands) and re-transmit the screen.

**PROCEDURE FOR COMPLETING AND PLACING LABELS ON THE REGISTRATION, AUTHORIZATIONS, CERTIFICATIONS, AND CONSENTS FORM (CH-5)**

The registration labels are to be placed on the Registration, Authorizations, Certifications, and Consents Form (CH-5). The labels are numbered 1 thru 5.

Labels are to be placed in the brackets as numbered 1, 2, 3, 4 and 5.

A financial certification block must be checked in order to comply with the federal and state regulations and the patient/parent/guardian must sign the income eligibility statement below the labels and the financial certification block to certify the income and other government benefits information is correct.

### **CONSENT FOR HEALTH SERVICES**

**Must** be signed once a year giving the clinic permission to provide health services as stated.

### **PERMISSION TO BE CALLED AS A REMINDER OF APPOINTMENT**

Patient/parent/legal guardian should check “Yes” or “No” if they give permission to be reminded of appointment via telephone.

For patients/parents/legal guardians calling in for appointments, permission should be obtained and that permission documented by entering a telephone number into the appointment system or documenting in the medical record if one exists. If patient denies permission, *no* telephone number should be entered into the system.

### **ASSIGNMENT OF BENEFITS**

Must be signed for every patient who has a third party payor. Name of the health department must be spelled out. Form should be checked, signed and dated. Support staff should obtain signature.

### **WIC RIGHTS AND RESPONSIBILITIES**

The patient or authorized person must read or have explained, then sign and date at the time of every certification or recertification. Signature should be obtained by staff discussing the patient’s rights and responsibilities.

**FORM CH-5**

**REGISTRATION, AUTHORIZATIONS,  
CERTIFICATIONS AND CONSENTS**

**Access this form on CDP's website**

**<https://www.cdpehs.com/downloads.asp?id=2>**

\*\*\*\*\*

**FORM CH-5B**

**PATIENT REGISTRATION AND INCOME  
DETERMINATION**

**Access this form on CDP's website at:**

**<https://www.cdpehs.com/downloads.asp?id=2>**

# PATIENT REGISTRATION AND INCOME DETERMINATION (CH-5B)

## WHEN TO COMPLETE A PATIENT REGISTRATION AND INCOME DETERMINATION (CH-5B)

A "Patient Registration and Income Determination" is completed when a personal health service is provided through a face-to-face encounter between a provider and a patient, and an entry is made in the medical record. The form is designed to accommodate all local health department service delivery sites that are not connected to the computer network or if the network is down. The completed CH-5B is then filed in the patient's medical record.

## HOW TO COMPLETE THE FORM

For all services provided, the questions regarding the patient demographics, billing, and eligibility information will be collected and documented.

### **LHD USE ONLY**

**Patient ID #/Date:** Record the patient's identification number and date.

**ID Proof Code:** This field is to be completed for WIC certification only. Enter the code for the type of proof presented for the identity of the person being certified. See Appendices for ["Instructions for Completing WIC Proof Fields."](#)

**Date Privacy Policy Signed:** This field is to be completed with date patient signed Privacy Notice. Month/Day/Year Example: 050303

**1. Patient Name:** *If patient is a Medicaid or Medicare recipient, enter name exactly as it appears on the Medicaid or Medicare card.*

Enter the patient's last name. Do not use dashes, slashes, apostrophes, commas, periods, or any other special characters/symbols. Sample entry: MCCONNELL. Up to 17 alpha characters may be used.

Enter the patient's first name. Up to 12 alpha characters may be entered. If the patient's name contains Jr., Sr., I, II, or III, these should be entered as part of the first name.

Enter the patient's middle initial. For example, Sam (no middle name) Jones, Sr., would be recorded as Jones for last name and Sam Sr in the first name field. Do not use dashes, slashes, apostrophes, commas, periods or any other special characters/symbols.

If patient has no middle initial leave blank. If patient has a health department pseudo number with a dash for the middle initial, you must enter a dash in the middle initial field.

Enter patient's maiden name. If no maiden name leave blank.

## 2. Patient ID Number:

If the patient's ID number is not brought forward to the screen, enter patient's identification number.

This number is the primary means of identifying and counting patients. Accurately recording the same patient number on every visit is important. The patient's ID Number is his/her Social Security or pseudo number. It is no longer the Medicaid number.

If a patient does not have a Social Security number, assign a pseudo number as follows:

1. The first character is the first letter of the patient's first name.
2. The second character is the first letter of the middle or maiden name. If the patient has no middle name or maiden name, record a dash (-).
3. The third character is the first letter of the last name.
4. The fourth and fifth digits consist of the numeric month of birth.
5. The sixth and seventh digits consist of the day of birth.
6. The eighth and ninth digits consist of the year of birth.

For example, if the patient's name is Mary Jane Smith, born August 5, 1950, the pseudo number would be: MJS080550.

If there are twins, triplets or quadruplets with the same initials:

First duplicate - add 40 to day of birth.

Second duplicate - add 50 to day of birth.

Third duplicate - add 60 to day of birth.

For example, if the patients are twins with the same initials, Keith Lee Roberts and Kenny Lewis Roberts, born June 30, 1960, the pseudo numbers would be:

Keith Lee            KLR063060

Kenny Lewis        KLR067060

To assign numbers to persons with same initials and birth dates other than twins, triplets, and quadruplets; add twenty to the birth month of the first duplicate, ten to the second duplicate, and ten to the third duplicate, etc. Examples of patient number assignments for persons with same initials and birth dates other than twins, triplets, and quadruplets:

<u>Patient Number</u>	<u>Name</u>	<u>Birth Date</u>
RAS121570	Ronald Albert Smith	Dec. 15, 1970
RAS321570	Robert Allen Sutherland	Dec. 15, 1970
RAS421570	Richard Alvin Scott	Dec. 15, 1970
RAS521570	Raymond Alan Suter	Dec. 15, 1970

### 3. Medicaid #

If the patient's Medicaid number is not brought forward to the screen, enter the patient's Medicaid number. Patients who have applied or are potentially eligible (A) for Medicaid will not have an entry in this field until the Medicaid number is assigned. Presumptively eligible Medicaid clients will be assigned a number on the day they apply (E).

**4. Address (Mailing):** Record the patient's current street address, rural route, or P.O. Box number.

**City/County/St/Zp:** Record the patient's city, county, state and zip code.

**Directions to Home:** Record directions to home if needed.

**Residence Proof Code:** This field is to be completed for WIC certification only. Enter the code for the type of proof presented for the residence (res.) of the person being certified. See Appendices for ["Instructions for Completing WIC Proof Fields."](#)

**5. Birth Date:** Record the patient's date of birth using the following format: Month/Day/Year: Example: 08271995.

**6. Sex:** Check female or male.

**7. Race:** Check all races as self-declared by the patient. Explain that this information is collected for reporting purposes and has no effect on any eligibility.

- **W (White)** – A person having origins in any of the original peoples of Europe, Middle East, or North Africa.
- **B (Black or African American)** – A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or

African American.”

- **N** (American Indian or Alaska Native) – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachments.
- **A** (Asian) – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **H** (Native Hawaiian or Other Pacific Islander) – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**His/Lat (Hispanic/Latino)**

Enter “Y” (yes) or “N” (no) for the patient’s self-declared ethnicity for Hispanic or Latino. Hispanic or Latino is a person of Cuban, Mexican, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”

**8. Special Eligibility:** Check all that apply to the patient:

**VOC:** Check if the patient is a VOC/transfer from another WIC site. VOC is for Verification of Certification for WIC.  
If the patient is a VOC transfer, income eligibility determination is not required for WIC.

**WIC Household:** Enter Y (Yes) if the patient is a WIC applicant who lives in a household with a pregnant woman who is fully eligible or presumptively eligible for Medicaid, or with an infant who is eligible for Medicaid, or with any household member who receives KTAP, or is an infant whose mother received Medicaid at the time of delivery, and documentation is observed.. See Appendices, WIC Income Eligibility Requirements, [“Adjunct Eligibility.”](#)

**9. Is it OK for us to phone or send mail to your home?**

If home contact is desired, check yes and list home and work number.

**Phone # (home):** Record the patient’s area code and home phone number if home contact is desired by the patient. If the person prefers to provide a cell phone number, enter that area code and phone number.

**Phone # (work):** Record the patient's area code and work phone number if the patient can be contacted at work. If the person prefers to provide a cell phone number, enter that area code and phone number.

**If no, how can we contact you?** Explain how we can reach you.

**Emergency Contact:**

Record the first and last name, address and phone number of the person to be contacted in case of an emergency.

**Is it OK for us to use an automated telephone message to remind you of your appointments?:**

If appointment reminder by the autodialer is desired, check yes. If contact by the autodialer is not desired, check no.

- 10. Person Responsible For Payment:** Record the first, middle initial, and last name of the person responsible for payment if different from patient's.
- 11. Mother's Maiden Name:** Record the first and maiden name of the patient's mother when appropriate.
- 12. Medicare:** Check yes or no. Medicare status must be on the patient's record on each visit. NOTE: If the patient has a Medicaid card, and if he/she is eligible for Medicare, the Medicaid card will indicate the Medicare coverage.
- 13. KTAP:** Check yes or no. This item applies solely to the patient.  
**Proof Code:** This field is to be completed for WIC certification only. If KTAP is yes and proof is presented, enter the code for the type of proof presented verifying KTAP eligibility for the person being certified. See Appendices for ["Instructions for Completing WIC Proof Fields."](#)
- 14. Food Stamps:** Check yes or no. This item applies solely to the patient.  
**Proof Code:** This field is to be completed for WIC certification only. If Food Stamps is yes and proof is presented, enter the code for the type of proof presented verifying Food Stamps eligibility for the person being certified. See Appendices for ["Instructions for Completing WIC Proof Fields."](#)
- 15. Health Insurance:** Check yes or no. If patient has insurance and the No Home Contact has been flagged, insurance is not to be billed, therefore 999 should be recorded in the ICD field on the PEF entry screen.

Record company name, insurance code, subscriber, contract code, and subscriber number.

**16. Third Party Payor:** Will charges be paid by an other third party? Check yes or no. If yes, record three (3) digit contract code.

**17. KEIS:** Check yes or no if the patient is receiving KEIS services. If yes, record the KEIS child ID number.

**18. Fixed Full Charge:  
(FFC)** Check yes when the services on the encounter are to be assigned the fixed full charge.

**19. Medicaid:** Check the answer applicable to the patient from the following:

**Yes** if the patient has a current Medicaid card or is eligible for the BCCTP. If (Y) Is marked the patient ID # must have the ten-digit Medicaid number. The Medicaid card should be reviewed for indication of whether the patient has insurance or Medicare. The indicator is on the front of the card in the last column on the right. Code identification is on back of card. If patient says they do not have a card with them – check MDID screen for eligibility when system access is available.

**No** if the patient does not have Medicaid, has not applied or is not potentially eligible.

**Applied** if the patient has applied for Medicaid.

**Mother** if the patient is an infant whose mother was Medicaid eligible at the time of delivery. This is applicable for 60 days after birth and is treated as pending in the system.

**KCHIP** if the patient presents an insurance card that identifies them as having K-CHIP Phase III.

Because Medicaid eligibility status changes from month to month, it must be checked at each initial monthly visit.

**(E)** Is entered if the patient is presumptively eligible for Medicaid.

**20. Kenpac:** Record the first, middle and last name of the KENPAC provider. This item applies only to patients on the Kentucky Medicaid KENPAC program. If KENPAC approval is necessary for the service reported, approval is to be obtained from the patient's KENPAC physician and that physician's name entered here. To indicate approval was given by the KENPAC physician for each service provided, it is necessary to record the KENPAC Physician # and enter a dash before the CPT code on the PEF.

**Medicaid  
Managed Care  
Partnership #:**

Check Yes or No if the patient is covered under a Medicaid Managed Care Partnership. If yes, record the partnership number. (See Appendices for additional MDID instructions.)

**21. Number In  
Household:**

Record the number in household which is used in conjunction with income to determine fee assessment and eligibility. The number recorded here is defined in the Appendices. An entry is required for this item on each initial visit to the health department and every 6 months thereafter if the visit includes services requiring income. See Appendices for [“WIC Income Eligibility Requirements.”](#)

NOTE: Income determination is required at each WIC Certification visit.

**# Persons With  
Income:**

Record the number of persons in the household that have income, and then list each person and their source of income as directed.

**SALARY AND INCOME OF PATIENT AND HOUSEHOLD MEMBER(S)**

When income determination is required, the entire patient and patient’s household income is to be considered and recorded by type and name of household member receiving income. See Appendices for definition of income.

**Name of Household  
Member(s):**

Record the name of patient and/or household members who work.

**Name of Employer(s):**

Record employer and employer address of patient and/or household members who work.

**Proof Code:**

Must complete for WIC certification and recertification. Record the code from the instruction sheet in the Appendices section for the type of proof presented for each income indicated. For “other,” document the type of proof presented in the patient’s chart.

**Monthly/Annual  
Amount:**

Record the monthly or annual income amount for each working household member.

**Other Income:**

Record the name of patient and household member(s) receiving other income; record the type of income: KTAP, SSI, Ret. Pension, Black Lung, Social Security, Vet. Benefits, Unemp./Work Comp., Child Support Alimony, Other.

**Proof Codes:**

Record the code from the list in the Appendices for type of proof presented for each income indicated for WIC certification and

recertification.

**Monthly/Annual  
Amount:**

Record the monthly or annual income amount for each type of income received.

**22. Average Income:**

Check yes or no. If no, record the average. Calculate the total income for the previous 12 month period for annual income. If the income has been received for less than a year, manually calculate the amount received for the past year.

**Financial Certification and Consent for Health Services:**

Check the applicable box if the patient is participating in an income eligible program. The patient/parent/guardian must sign the financial certification and consent for health services to certify the income and other government benefits information to comply with Federal and State regulation and provide consent for service provision.

**Payment for Service/Assignment of Benefits:**

The patient or authorized person must sign and date if the patient has a Third Party Payor, such as Medicare, Medicaid, and private insurance.

**WIC Rights and Responsibilities:**

The patient or authorized person must read or have the WIC Rights and Responsibilities explained to them, then sign and date the form at each WIC certification and recertification.

**PATIENT ENCOUNTER FORM (PEF)  
And  
PEF CODING SHEET**

**Access this form on CDP's website at:**

<https://www.cdpehs.com/downloads.asp?id=2>

## **PATIENT ENCOUNTER FORM (PEF) (CH-45)**

### **WHEN TO COMPLETE A PATIENT ENCOUNTER FORM**

A patient encounter form is completed when a personal health service is provided through a face-to-face encounter between a provider and a patient, and an entry is made in the medical record. There may be several procedures and providers involved in the visit. The provider writes his or her number for the procedure as described in the definitions of the procedures.

In addition to collecting the traditional health services information provided by or through the local health departments, the PEF collects and feeds information collected during the visit to the WIC subsystem and the Breast and Cervical Cancer Screening and Follow-up Reporting Subsystem.

The PEF follows the patient through the clinic with the medical record and the services/procedures are marked when provided.

### **HOW TO COMPLETE THE FORM**

For all services provided in the health department, i.e., in-clinic services, the patient will be registered and the questions regarding patient demographics, billing and eligibility information will be collected and entered at that time. A PEF label (P Label) will be printed at the end of the registration process and is then affixed to the encounter form in the top right corner over the document number, date, patient name, and ID number.

The form was designed listing commonly reported services as check-off boxes on the front. The service provider should simply check the appropriate box, enter their provider number and any additional required information (ICD(s), REF/DISP, UNITS, etc.). Space is provided on the back of the form to write in additional services (up to 8 CPTs/HDPTs). The separate coding sheet for less commonly reported services is updated and distributed as changes occur.

For service delivery sites that are not connected to the computer network or if the network is down, a CH-5B, Patient Registration and Income Determination, must be completed and filed in the medical record.

### **PEF FORM FRONT:**

#### ***FFC (Fixed Full Charge)***

Enter an (F) when the services on the encounter are to be assigned the fixed full charge.

#### ***CnctC (Contract Code):***

Enter the three (3) digit contract code assigned to the third party payor (see “Billing Procedures That Are Not part Of PEF Entry” section for instructions on assigning contract codes.

***LEP:*** Enter Y/N for Limited English Proficiency.

***PLACE OF SERVICE/PAYMENT:***

If the service occurred outside the health department, select the appropriate code from the list at the bottom of the form.

***CLINIC VISITS:***

The CPT (Physicians' Current Procedural Terminology) and HDPT (Health Departments' Procedural Terminology) codes will be used to identify and count services. The Physicians Current Procedural Terminology (CPT), Fourth Edition, is a systematic listing and coding of procedures and services performed by physicians. Since many health department services are provided by health workers other than physicians, codes have been developed by the Kentucky Department for Public Health which are HDPT - Health Department Procedure Terminology Codes. The HDPT codes are consistent with the CPT coding structure except they are designed for non-physician providers.

***CPT/HDPT CODES (Check-off section):***

***MODIFIER:***

Circle modifiers as appropriate.

***PROVIDER:***

On the line where the service is being recorded, enter the five-character Provider class-ID number which uniquely identifies the service provider. The Provider Number must be reported with each CPT/HDPT code.

The SERVICE PROVIDER is the individual who assumes primary responsibility for assessing the patient and exercises independent judgment as to the services provided to the patient during the visit. The individual must be providing a face-to-face medical or counseling service and be acting independently, not assisting another provider in the service. If two or more providers are present and participate in the service delivery, the provider to be recorded is the individual in charge of the health service delivery.

All individuals providing patient services within the local health department and documenting in the medical record must be listed on a Provider Legend that is on file at the health department. Contractors, employees from another health department, students, volunteers, etc., must be included on the list. The list must contain the printed name, title of provider, signature, signed initials, employee ID number, and the period of employment. The Provider Legend is maintained permanently at the health department.

This provider may be one of the following:

- Employee on payroll, including personal service contract (PSC) providers;
- Independent contract providers;
- State university or Department for Public Health providers;
- Other providers who do not fit in any other category.

Provider class-ID numbers are to be assigned and maintained for each type of local health department personnel as follows:

1. For payroll employees the provider class-ID numbers are assigned by the Local Health Personnel Branch, Division of Administration and Financial Management. (See Appendices for List).
2. The personal services contractors, independent contractors and 800 numbers are assigned provider numbers through the Division of Administration and Financial Management, Cabinet for Health and Family Services. (See Appendices for list).

Provider classifications are assigned a CPT Provider classification code which is an integral part of the billing code assignment of the CPT file. (See Appendices for Employee Classification – CPT Assignment codes).

NOTE: The state and university health professional provider numbers and the other providers not elsewhere classified are assigned by the Resource Management Division. If any problems or questions arise, please call (502) 564-6663.

***ICD - 9 - CM CODE (diagnosis 1-4):***

The ICD-9-CM code is required to be entered with all visit CPT/HDPT codes except the WIC codes W0200 - W0209. These WIC codes will be assigned the 2699 - Nutritional Deficiency (unspecified) by the computer.

The code indicates the reason for visit in the first position (primary). The ICD recorded as Primary will be used to identify the Cost Center to which the visit is assigned. See Cost Center assignment list in Appendices.

Second, third and fourth position ICD-9 codes should be used for diagnosis to which money is attached or are program requirements.

The code recorded in the second position may be the problem found during an examination, e.g., during well child exam, or it could be the secondary diagnosis as determined by the clinician's medical diagnosis. Also the secondary ICD is used to identify the secondary reason for the visit, e.g., TB treatment may be primary and Family Planning contraceptive management secondary.

***REFERRAL:***

Referral coding is no longer a requirement. If an agency wishes to track referrals made, see instructions that follow.

Enter the code for the discipline of the person/agency to whom the patient was referred.

Record only referrals to an agency or health care provider outside the local health department. Exception: Report referrals to a contract physician outside the health department in regional pediatrics and the Well Child or EPSDT program. If more than one referral is made for the service being reported, enter the CPT/HDPT, ICD, etc., on the first line entry with one of the referrals, then on the next line directly under, enter the additional referral codes. Select the appropriate code from the list at the bottom of the form.

**LOT#:**

Enter the code for the Immunization Lot# assigned by the Kentucky Vaccine Inventory System.

**UNITS:**

In accordance with the CPT Book, units are recorded when the procedure is provided/conducted more than once and the definition states the code be used for each procedure. For CPT and HCPCS codes, units must be reported when the definition of the code requires that units of service be reported.

**PEF FORM BACK:**

**FAMILY PLANNING VISITS**

**CONTRACEPTIVES, QUANTITY ISSUED and LOT#:**

All contraceptive methods being administered during a Family Planning Visit must be reported as an “S”, “J” or CPT code. If reporting an HDPT code which requires the amount/quantity, enter the quantity in the space provided following the appropriate code.

**PRIMARY METHOD PATIENT IS USING IF NO METHOD GIVEN TODAY:**

The “2” digit codes are used only for Family Planning Visits where no contraceptive method is given to the patient. For reporting purposes only, these “2” digit codes are used to identify what contraceptive method the patient is using. Place a check in the box preceding the appropriate method.

**ADDITIONAL CPT/HDPT CODES (not listed as check-off box on front of form):**

Space also provided to write-in CPT Modifiers, referrals, charge/quantity, units and/or override codes as needed.

**OVERRIDE AREA:**

This area is used to override certain edits/rules the computer applies. One of the rules is Payor Code Assignment.

When providing services to employees of the local health departments that are required as a condition of employment or for flu vaccine for employees, enter a P4 for payor code 4 “non-assigned” in the override area. If a patient needs services repeated because of an error by the health department or laboratory, etc, override the reported services with payor code 4. If patient receives a service paid by a contract provider and elects to receive other services on the same day, these other services should have P1 (self pay) added to the override area so that the patient can be billed for these services only. To override Cost Center enter “N” and Cost Center code. To enter Immunizations Lot# enter “V” and lot#.

**NET TOTAL CHARGES:**

This item will be calculated by the computer. If your center is not on-line, please complete. Add the total of all "charge" entries. Enter the exact amount in dollars and cents. Sample entry: 30.00

**AMOUNT PAID TODAY:**

Enter the actual amount that was collected from the patient if the computer system is down or if your department is not connected to the system. Sample entry: 15.00

**WIC VISITS:**

**HDPT Codes (Check-off Section)** Check the space in front of the service provided.

**W0200 Certified & Enrolled** – Used by a certifying health professional when a person is determined eligible and added (enrolled) to the WIC Program. (See the WIC Section of the PPHR)

**W0201 Certified Waiting List** – Used by a certifying health professional when a person is determined eligible (See the WIC Section of the PPHR) and placed on the Waiting List. This service is used only when directed by the State WIC Office.

**W0202 Enrolled From Wait List** - Used when a person is removed from the Waiting List and added to the WIC Program.

**W0203 Screened Not Eligible – Inc** – Used when a person has been determined not eligible at certification/recertification for the WIC Program based upon the income screening.

**W0204 Scr Not Elig – Risk** – Used when a certifying health professional has determined at certification/recertification that the person is not eligible for the Program based upon nutritional risk criteria.

**W0208 VOC Enrollment** – Used when a person has transferred into the site with valid certification still remaining. (See the AR, Volume II, WIC Section)

**W0209 Food Instruments** – Used when any type of food instruments (WIC or WIC FMNP) are issued. (See the AR, Volume II, WIC Section)

**W0210 – Issuing a Breast Pump** – Used when any type of breast pump (hand pump, single user or hospital grade) is issued to a WIC participant.

**W0220 – Capillary Blood Specimen** – Used when a hemoglobin has been done in conjunction with no other service than a WIC certification. This code will go into the system as a WIC code and not charge Medicaid or the patient. The system will change the W0220 to the correct HDPT code.

**W0230 – Hemoglobin** – Used when a hemoglobin has been done in conjunction with no other service than WIC certification. This code will go into the system as a WIC code and not charge Medicaid or the patient. The system will change the W0230 to the correct HDPT code.

**W0240 – Hematocrit** – Used when a hematocrit has been done in conjunction with no other service than WIC certification. This code will go into the system as a WIC code and not charge Medicaid or the patient. The system will change the W0240 to the correct HDPT code.

Provider: More than one space is indicated for Provider. Multiple providers can provide the above services, i.e. the nurse or nutritionist would code a W0200 and support staff code W0209 during the same visit.

**WIC Nutrition Education/Counseling:**

The below codes are used when nutrition education counseling is provided to a WIC participant or the participant's parent, caretaker or proxy by a certifying health professional. See the WIC Certification Counseling Guidelines and the WIC Follow-Up Counseling Guidelines in the WIC Section of the PHPR.

**W9401 WIC Nutrition Ed/Counseling (7.5)** – Used when the counseling protocol is followed and documented in the medical record. Use for time up to 7.5 minutes.

**W9402 WIC Nutrition Ed/ Counseling (15)** – Used when the counseling is above the WIC protocol for time up to 15 minutes. Additional counseling must be documented in the medical record.

**W9403 WIC Nutrition Ed/Counseling (22.5)** – Used when the counseling is above the WIC protocol for time up to 22.5 minutes. Additional counseling must be documented in the medical record.

**W9404 WIC Nutrition Ed/Counseling (30)** – Used when the counseling is above the WIC protocol for time up to 30 minutes. Additional counseling must be documented in the medical record.

**PROVIDER:**

Record the provider number of a health professional. There is space for 2 providers to use in the instance that one provider counsels on WIC Nutrition Education (ICD) (2699-) and a separate provider gives counseling on breastfeeding (ICD V241-).

**ICD**

Record the appropriate ICD in the box under provider.

- 2699- for WIC Nutrition Education
- V241- for lactation supervision is used when breastfeeding counseling is above the certification or follow-up counseling protocol for a pregnant or breastfeeding woman.

**WIC LOW RISK FOLLOW-UP CONTACT:**

The following codes are used by trained paraprofessionals.

**WP401 WIC Low Risk Follow-up Contact (7.5)** – used for time up to 7.5 minutes.

**WP402 WIC Low Risk Follow-Up Contact (15)** – used for time up to 15 minutes.

**WIC Status** – Circle the appropriate status of the WIC participant:

(I) Infant, (P) Pregnant, (BF) Breastfeeding, (C) Child, or (PP) Postpartum.

See the WIC Program section in AR, Volume II for the definition of each status.

**Action** - Circle the appropriate WIC Action:

- (A) add – The initial certification and enrollment of a WIC participant. Also used to add a transfer.
- (B) breastfeeding data change – To correct responses already in the system for the breastfed infant.
- (C) change – To change participant data. DO not use this action to replace food instruments when a food package change is needed.
- (R) recert (recertification) – Subsequent certification of an enrolled person.
- (T) termin. – Termination of a WIC participant.
- (W) wait. list (Waiting List) – Used only at the direction of the State WIC Office when caseload is at maximum.
- (X) reinst. – Reinstating a person that was terminated and has certification/eligibility remaining.
- (P) print – Printing automated food instruments.
- (Z) replace – Replacement of issued food instruments due to a food package change or food instruments that have been lost stolen or destroyed.

**Actn. Date (Action Date)** – Date the WIC action is transmitted.

**Init. (Initial) Contact date** – Date of first visit to the clinic to request WIC. Complete only for an A (add) action.

**Certification Date** – Date of the certification. This date may be prior to the Action date.

**Expec. Deliv. Date (expected delivery)** – Complete for a pregnant woman. This is the date the infant is due.

**Actual Deliv. (delivery) date** – Complete for a postpartum or breastfeeding woman. This is the date the infant was delivered.

**Birthweight** – Complete for an infant certification and when the child is less than two (2) years old. This is the pounds (lbs) and ounces (oz) birthweight of the infant.

**Nutritional Risk Criteria** – Complete for all status and all certification actions. Risks are determined by the certifying health professional. See the WIC section of the PUBLIC HEALTH PRACTICE REFERENCE for risk codes.

**Date of Measure** – Date of the measurements used for certification.

**Height/Length** – Height or length in feet (ft.) and inches (in.). The fractions must be in multiples of 1/8.

**Weight** – Pounds (lbs.) and ounces (oz.) used for certification.

**Date of Measure** – 2<sup>nd</sup> date is date of hemoglobin and hematocrit only, if the date is different then the one used for height and weight. If no date is entered, it defaults to first date of measures.

**Hemoglobin** – Hemoglobin used for certification, cannot be less than 4.9 or greater than 20.0.

**Hematocrit** – Hematocrit used for certification, cannot be less than 10 or greater than 45.0.

**Food pkg. (package) code** – Food package code assigned by the health professional. See the WIC section of the PUBLIC HEALTH PRACTICE REFERENCE for the food package codes.

**1<sup>st</sup> full pkg. (package) iss. (issuance) (m/d)** – First valid date or first day to use for first full month's food instruments. This date must be the same as other family members who are receiving WIC benefits. See the WIC PROGRAM section in AR, Volume II for guidance on putting family members on the same issuance date.

**Physically Present** – Complete the yes/no field for physical presence of the person being certified. If no, one of the exempt reasons 1-4 must be documented. See the WIC PROGRAM section in AR, Volume II for WIC Eligibility Requirements.

**Special formula name** – Complete only when the food package code does not provide a specific formula name. See the WIC section of the PHPR for food packages.

**Prescription expir. (expiration) date** – Complete for all formulas other than contract brand. This is the last day that the prescription is valid.

**The following breastfeeding questions are to be completed until the infant/child is 24 months of age or until the infant/child is no longer breastfeeding.**

**Currently breastfeeding/fed breast milk from bottle/cup?. Yes No Unknown** – Indicate yes or no if the **infant** participant is being currently breastfed or fed breast milk from a bottle/cup at least 1 time a day. Indicate unknown if the caretaker/proxy does not know the answer to the question.

**Ever breastfed/fed breast milk from bottle/cup?. Yes No Unknown**  
Indicate yes or no if the infant participant was ever breastfed or fed breast milk from a bottle/cup. Indicate unknown if the caretaker/proxy does not know the answer to the question.

**If yes, how long? #days, # weeks, # months** – If yes is answered to ever breastfed - Determine the length of time the infant/child was breastfed.

**Fed infant formula or any other food besides breast milk? Yes No Unknown**

If yes, age when other foods were fed? – If the infant was currently or ever breastfed, indicate the age when the infant was fed any infant formula or any other food besides breast milk. Use the following:

- < 7 months
- > 7 months
- Only fed breast milk
- Unknown

**TV viewing? No. of hours per day** – complete for children 24 months old or older. Indicate the number of hours per day spent watching television. Use the following numbers:

- 0 = 0 and less than 1 hour per day
- 1 = 1 hour per day
- 2 = 2 hours per day
- 3 = 3 hours per day
- 4 = 4 hours per day
- 5 = 5 or more hours per day
- 6 = None
- 9 or blank = unknown

Completion of TV viewing is an option. If the field is completed, the data will be reported to the Centers for Disease Control and will be returned to the agency via PEDNSS reports.

**Issuance 1mo, 2mo, 3 mo** – Complete the number of months of issuance requested.

**Replacement pkg. (package) code** – Complete when doing a (Z) Replacement action. If the food package is changing, enter the new food package code. Refer to the WIC PROGRAM section in AR, Volume II for guidance on replacing food packages.

**Replace current month pkg. (package)** – Indicate the quantity of formula, cereal or juice returned for the current month of issuance. The quantity returned will be either actual formula, food or the amount on the returned food instruments.

**WIC replacement – Circle FI replaced 1, 2, 3** – When replacing a woman/child food package, circle the 1, 2 or 3 to be replaced in the current month, i.e., if the 2<sup>nd</sup> and 3<sup>rd</sup> food instruments are to be replaced, circle the 2 and 3.

# **PEF ENTRY AND OTHER BILLING PROCEDURES**

## **HOW TO ENTER ENCOUNTER SERVICES BY DOCUMENT NUMBER**

After the registration screen(s) have been built, services may be entered. The user must be logged onto the PEF System, and simply recall the menu. For those patients seen offsite, the user should enter the PEF's by patient ID number.

### **COMMAND: XEBARCAL<XMIT>**

Enter X by PEF number, and enter the PEF number assigned for the PEF. The PEF number will be in the top right corner of the PEF Label. After you have transmitted the menu screen, the encounter entry screen will be displayed from registration.

Enter the service data now. Generally only a couple of entries will be necessary, i.e., the service code(s) and provider number. You cannot enter the next encounter through the PEF screen, you must recall the menu and enter the next document number. Another function for entering encounters is: **XEBAPEF <space><PEF#><XMIT>**

If needed, subsequent encounters may be entered through this command by entering the next PEF number in the CUR field. When the PEF number is entered the next encounter will be displayed.

## **INSTRUCTIONS FOR COMPLETING THE ENCOUNTER ENTRY SCREEN**

The Encounter Entry Screen will be brought forward filled in with information which was entered on the Registration Screen. Insurance Code, FFC, CNCT Cd and Ps/P must be completed on the Encounter Entry Screen. Instructions for completing these fields are included in the PEF instructions.

There is space for 12 CPT/HDPT codes in the top section of the screen. For CPTs which do not require the ICD, units, referrals, or overrides (CPT classes 50, 60, and 70) may be entered in the bottom (overflow) section.

Additional PEF Entry Screen Fields:

- At      Attending physician (Fayette County Use Only)
- Se      Sec. Prov. (Fayette County Use Only)
- Ap      (Enter "X") Used to tell the system to bring forward the appointment screen
- Bl      (Enter "X") This item is to tell system to bring forward the bill screen when there is an exception to demand the bill screen.

NOTE: If “No Home Contact” is indicated on the patient computer master record and the patient has a previous balance containing family planning or STD services, the bill screen will be displayed with today’s charges and only non-family planning and non-STD previous balances. If the patient is alone and/or if the entire account including previous family planning or STD charges is needed, an “A” is entered in the bill screen box. All balances will be displayed and will be included on the printed bill/receipt.

Lx     Fayette County Use Only

SR     Enter “Y” if you want the Supplemental Screen returned to enter services that cannot be entered on the Encounter Form.

Cur    The Encounter number for the next PEF may be entered for encounters being entered in a batch mode from remote sites.

Once the services are entered and the screen is transmitted, if there is a patient fee, the bill screen will be displayed. If there is a WIC certification service entered, the WIC screen will also be displayed.

The bill screen indicates the charge and any previously owed balances. If money is collected enter the amount collected for Billing Code 1 (Patient Self-Pay) in the “Bc1” field. Enter the amount collected for “other”, such as Billing Code 15 (Patient Paid Co-Insurance and Deductible) in the “Other” field, and transmit the screen. The patient bill/receipt prints. Remove the receipt from printer and initial the receipt and give it to the patient. The WIC Screen should be completed and WIC food instruments and a WIC Issuance label for the Medical Record are printed. If no money was collected, but a bill for the patient is needed, put a “Y” in the Print Bill block and transmit.

Fields displayed on the bill screen are as follows:

Vs [ ] Visit charge for patient.

Ag [ ] Agency assumed amount.

Bc1 [ ] Billing Code 1 – Amount patient actually owes.

Otr [ ] Total amount due from patient for today’s visit for Co-Insurance (PC15).

Prv: Bc1 [ ] Balance from previous visits that was Self-pay.

    Otr [ ] Previous balance for Co-Insurance (PC15).

Due [ ] Amount due for Private Pay and Co-Insurance.

Col:Bc1 [ ] Amount collected today for Private Pay.

    Otr [ ] Collected today for Co-Insurance.

    Don [ ] Today’s donated amount.

Prn [ ] Enter X or Y if need bill printed – Enter “F” in this field when entering a service provided by an Independent Contractor following receipt of Invoice and medical record documentation. Two (2) “F” labels will be generated. Should you need more than two “F” labels, 3-9 may be entered and that number of labels will be printed.

#Cp [ ] Enter # of bill copies you need printed.

Also available is the check-out insurance billing procedure. If 999 is entered in the INSCD field of the PEF entry screen, and total payment of the invoice is made then an insurance bill will be immediately created at PEF entry.

NOTE: Patient Paid Co-Insurance/Co-Payment (Billing Code 15) will also be billed at this time.

Also available is the check-out other third party billing procedure. If 999 is entered in the (CnctC) field of the PEF entry screen, an other third party bill will be immediately created.

NOTE: Due to the varied nature of the services that are covered by other third parties, it is impossible to have the Patient Services Reporting System automatically determine if the services provided to a patient can be billed to another third party. When the PEF is entered for a visit that is covered, override the payor code with a "P8".

**Patient Encounter Forms:** All voided PEFs must be retained along with the daily entry PEFs and Supplemental forms. See Retention Schedule in Section X of Volume I Administrative Reference.

## **PATIENT ID NUMBER CHANGE PROCEDURE**

The system will not allow the operator to change a patient's ID number when building or updating the patient's master record. Enter the following:

### COMMAND:

**PCCK <Space><30><Space><LOC><Space><The Patient's Old ID#>  
<Space><LOC><Space><Patient's New ID Number><Space><CHGIT><XMIT>**

A patient's name may be changed when building or updating a patient's master record by simply typing over the name with the correct name.

## **MERGE PATIENT ID NUMBERS PROCEDURE**

To prevent having duplicate patient records for the same patient use the merge patient ID number if more than one patient record exists in system:

### COMMAND:

**MPAT<Space><30><Space><LOC><Space><Old Patient  
ID#><Space><LOC><Space><Current Patient ID #><Space><MERGE><XMIT>**

NOTE: Keeping the patient's correct ID Number in the system is critical. Periodically each health department will be sent a listing of patients who are in the system under two or more numbers. This listing is to be reviewed, and changes made to the record in the system. Special security access on user's KY Number is required for this function.

## UPDATE PATIENT RECORD

If the system locates the patient's records when doing a patient search (PSIZ or PSNR) the patient's file will automatically be displayed for the operator to update.

NOTE: At times it will be necessary when updating a patient's master record to clear a field on the screen, i.e., no home contact, patient's address, patient's phone #, etc. The following symbols must be used, as spaces remove nothing.

1. The dash (-) is only used with No Home Contact
2. The asterisk (\*) is used to clear alpha fields
3. The zero (0) is used to clear numeric fields, i.e., Income, Phone #
4. The (N) is used to clear flags; KenPAC, Insurance
5. Combination Fields that have two fields to fill in -  
Medicare [Y] Medicare # [            ] and/or  
KenPAC [Y] KenPAC # [        [        ] must first have the flag "Y"  
changed to "N" before system allows user to remove number # by  
keying \*\*\*\*\*.

## **BILLING PROCEDURES THAT ARE NOT PART OF PEF ENTRY**

### **PATIENT SELF-PAY (BILLING CODE #1)**

Monthly statements for patient pay account balances may be printed as follows:

**QUPR<space><SITE #><space><PRINTER #><space>3<space>ALL<XMIT>.**

Screen 501 will show when the monthly statements are ready for printing.

Payments received in the mail for amounts owed by patients may be entered using the following procedures.

1. Set up a cash target amount for the batch total dollar amount that you will be entering at one time. Use command **CDS304<XMIT>**.
2. You may review a patient's account with the command:  
**PARI<space>30<space><LOCATION><space><PAT ID><XMIT>**
3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:  
**S<space><PAYMENT><space>P<space><PAT ID><XMIT>**

### **MEDICAID BILLING (BILLING CODE #2)**

For local health departments that participate in the Medicaid Preventive Health Services Program, and also for KCHIP covered patients, the system will automatically bill the Program for covered services. The Medicaid Preventive Health Services manual contains specific information about this program. The services that are billable to the Preventive program and the approved rates are listed in the Appendices. Also, for local health departments that have contracted with Medicaid Managed Care entities, the system will automatically bill for covered services.

Each of the service providers for your department has a third party billing status "flag" (Yes) or (No) in their provider master record in the computer system. This flag is used by the system to determine if any third parties may be billed for each provider's services to a covered patient. All employees are automatically flagged yes. Each independent contractor is individually flagged based upon the information in their contract. Special statewide provider's third party billing status is determined and entered at the state level. Other provider's third party billing status must be determined by the local health department. Send listing of other providers to the Division of Administrative and Financial Management for entry into the provider master record in the PSRS.

We recommend that a Kentucky Medicaid Preventive Health Services Program Statement of Authorization – Other Providers form be obtained for each independent contractor and other provider used by your department. (See [Appendices](#).)

Additionally, at the end of each month, the Applied Potential Medicaid report #375 is available for each Medicaid preventive or Medicaid Managed Care site. The report lists all patients (and their PEFs with covered services) who were marked as applied potentially eligible for Medicaid in the computer system patient master record. PEFs containing WIC only services will not be listed. When the patient receives their Medicaid card, use the following procedures to bill Medicaid for those service dates that were covered:

1. The retro-active Medicaid screen for each patient is brought up using the command:  
**NERI<space>30<space><LOCATION><space><PATIENT ID#><XMIT>**
2. In the first column on the screen enter the correct code on the same line as the PEF you want to bill to Medicaid or on which you want to change the billing status. Allowable codes are:

Enter “Y” or “X” to flag Medicaid eligible. Covered services provided by billable providers will be added to the next Medicaid billing.

Enter “N” to flag patient not eligible for Medicaid on the date of the service. The PEF will no longer appear on the 375 report at the end of the month. If a self-pay charge results, the A/R amount will automatically be set up.

Enter “A” to re-flag Medicaid applied or potentially eligible. (Use for mistake correction.) If the patient has coverage through a Medicaid Managed Care Partnership, enter the region number in the Par # field. Transmit to change the billing status. The converting to Medicaid audit trail will be produced under print Queue 9.

REMEMBER: WIC only PEF’s will not be listed.

Corrections to individual PEFs in the history file will also enable covered services on the corrected PEFs to be automatically billed to Medicaid or Medicaid Managed Care if none of the services on that individual PEF have been previously computer billed to Medicaid or Medicaid Managed Care.

If your department needs to make mass changes to your Medicaid or Medicaid Managed Care billings due to a change in the billing status of an independent contractor or other provider or due to a retro-active addition of a site to the Preventive program, contact the Division of Administrative and Financial Management for specific instructions.

Denied Medicaid Preventive claims rebilling and billings for any services that were left off of a PEF that has already been billed must be submitted to the Medicaid program by using the CPOD functions. A separate electronic billing will be created for these claims. First, correct any errors in the PEF history file or patient master record that caused a denied claim. Also correct the patient’s accounts receivable for Medicaid using the following procedures:

1. Set up a cash target amount of \$0 since no cash will be involved in this type of patient accounts receivable transaction. Use command **CDS304<XMIT>**.
2. You may review a patient’s account with the command:  
**PARI<space>30<space><LOCATION><space><PAT ID><XMIT>**
3. Use the entry of cash receipts screen (CDS302) to enter each patient’s account receivable adjustments. Adjustments will include reducing the A/R for any services that were denied payment and cannot be re-billed or changes in the A/R amount for services that were denied payment and must be re-billed at a different rate. Any services that are being billed that were not billed electronically must have an amount set up in the patient’s A/R.

The following computer procedure is available to produce the electronic re-billing:

1. The electronic re-billing screen is brought up using the command:  
**CPOD<space>30<space><LOC><space><PEF#><space>2<space>2<XMIT>**

Use:

**CPOD<space>30<space><LOC><space><PEF#><space>9<space>2<XMIT>**  
for Insurance TPL Medicaid billing.

2. Review the information on the screen. Delete any services and associated information that have already been paid by Medicaid from a previous computer billing. For Insurance TPL billing, enter the amount paid by the insurance company in the insurance paid field.
3. Enter an invoice # in that field. If you are re-billing a denied claim, a number was already created by the computer for the first billing, so just use that number. If this is the first billing for a service that requires written documentation, or for Insurance TPL billing, use the invoice # that was used to create the patient account receivable.
4. Transmit the screen to create an electronic re-billing entry. If you must submit a paper CMS 1500 with documentation attached, or if required by your Medicaid Managed Care entity, put a "Y" in the CMS 1500 only field. An electronic billing entry will not be made if you use this field. At the conclusion of the paper CMS 1500 bill creation, all bills to all payors are printed in order on continuous CMS 1500 forms.

Use the command:

**MQP<space><PRINTER#><space>2<XMIT>**  
to release the print Queue and print the bills.

*Please remember that the above procedures only create an electronic billing entry or print a bill. No changes are made to the Patient's account receivable or the PEF history file by these procedures. Those changes have to be made separately.*

### **MEDICARE BILLING (BILLING CODE #3)**

Many Physician services, on-site laboratory services and Influenza and Pneumonia injections may be billed to the Medicare Physicians Services program. See the [Medicare Part B Physicians Office Desk Reference Manual](#) for specific information. Also available is a special program for billing only certain immunization services including influenza and pneumonia. If your department is enrolled in either program, Medicare services are automatically billed at the state level on a monthly basis.

Specific information for each clinic site and for physician or mid-level providers, including UPIN#, must be in the master files in the system. Contact the Division of Administration and Financial Management for assistance with these procedures.

Corrections to individual PEFs in the history file will enable covered services on the corrected PEF to be automatically billed to Medicare if any of the services on the PEF have not previously been electronically billed to Medicare.

Denied Medicare claims re-billings must be submitted to the Medicare carrier by using the CPOD function. A separate electronic billing will be created for these claims. First, correct any errors in the PEF history file or patient master record that caused a denied claim. Also correct the patients' account receivables for Medicare using the following procedures:

1. Set up a cash target amount of \$0 since no cash will be involved in the type of patient accounts receivable transaction. Use command **CDS304<XMIT>**.
2. You may review a patient's account with the command:  
**PARI<space>30<space><LOCATION><space><PAT ID><XMIT>**
3. Use the entry of cash receipts screen (CDS302) to enter each patient's accounts receivable adjustments. Adjustment will include reducing the A/R for any services that were denied payment and cannot be re-billed or changes in the A/R amount for services that were denied payment and must be re-billed at a different rate. Any services that are being re-billed that were not billed electronically must have an amount set up in the patient's A/R.

The following computer procedure is available to produce the electronic re-billings:

1. The electronic re-billing screen is brought up using the command:  
**CPOD<space>30<space><LOC><space><PEF><space>3<space>3<XMIT>**
2. Review the information on the screen. Delete any services and associated information that have already been paid by Medicare from a previous computer billing.
3. Enter an invoice # in that field. If you are re-billing a denied claim, a number was already created by the computer for the first billing so just use that number. If this is the first billing for a service, use the invoice # that was used to create the patient's account receivable.
4. Transmit the screen to create an electronic billing entry.  
*Please remember that the above procedure only creates an electronic billing entry. No changes are made to the Patient's account receivable or the PEF history file by this procedure. Those changes will have been made separately.*

### **INSURANCE BILLING (BILLING CODE #9)**

The billing procedures for insurance companies are similar to those available for the Medicare automated billing procedures. Insurance billings are automatically prepared at the state level on a monthly basis using information from the Patient Services Reporting System.

We use Medicare rules to determine if a service should be billed to an insurance company. If you want services in addition to those that would be included using the Medicare rules to be included in your insurance billings, please contact the Division of Financial and Administration.

The following computer procedure is available to print the CMS 1500 as part of the re-billing process: Correct any errors in the PEF history file or patient master record that caused a denied claim. Also correct the patients' account receivables for insurance.

1. The on-demand CMS 1500 billing screen is brought up using the command:  
**CPOD<space>30<space><LOC><space><PEF#><space>9<space> 9<XMIT>**
2. Review the information on the screen. Delete any services and associated information that have already been paid by insurance from a previous computer billing.
3. Enter an invoice # in that field. If you are rebilling a denied claim, a number was already created by the computer for the first billing, so just use that number. If this is the first billing for a service, use the invoice # that was used to create the patient's account receivable.
4. Transmit the screen to create a CMS 1500 under print queue #2. At the end of an on-demand CMS 1500 bill creation session, all bills to all payors are printed in order on continuous CMS 1500 forms. Use the command  
**MQP <space><PRINTER#><space>2<XMIT>**  
to release the print queue and print the bills.

*Please remember that the above procedure only prints a bill. No changes are made to the patient's account receivable or the PEF history file by this procedure. Those changes have to be made separately.*

Payments received for amounts owed by insurance companies may be entered using the following procedures:

1. Set up a cash target amount for the batch total dollar amount that you will be entering at one time. Use command **CDS304<XMIT>**.
2. You may review a patient's account with the command:  
**PARI<space>30<space><LOCATION><space><PAT ID><XMIT>**
3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:  
**I<space><PAYMENT><space>P<space><PAT ID><space><INV#><XMIT>**

### **OTHER THIRD PARTY BILLING (BILLING CODE #8)**

The billing procedures for other third parties are similar to those available for the insurance company automated billing procedures. Other third party billings are automatically prepared at the state level on a monthly basis using information from the Patient Services Reporting System. Since we currently lack sufficient volume to any one third party to bill them electronically, use report 736 Invoice Register as a billing document for these payors. If it requires a CMS 1500, described below.

To print the monthly CMS 1500 bills that are to be sent to other third parties, use the following procedures:

1. Your department will be notified via Screen 501 when the monthly bills are ready to be printed.
2. All bills to all other third parties are printed in order on continuous CMS 1500 forms. Use the command:  
**QUPR<space><SITE#><space><PRINTER#><space>765<space>ALL<XMIT>**  
to release the print queue and print the bills.  
Denied other third party claims re-billings must be submitted to the other third party via another paper CMS 1500 form. Correct any errors in the PEF history file or patient master record that caused a denied claim. Also correct the patients' account receivables for other third party.

The following computer procedure is available to print the CMS 1500 form as part of the re-billing process:

1. The on-demand CMS 1500 billing screen is brought up using the command:  
**CPOD<space>30<space><LOC><space><PEF#><space>8<space> 8<XMIT>**
2. Review the information on the screen. Delete any services and associated information that have already been paid by other third parties from a previous computer billing.
3. Enter an invoice # in that field. If you are re-billing a denied claim, a number was already created by the computer for the first billing, so just use that number. If this is the first billing for a service, use the invoice # that was used to create the patient's account receivable.
4. Transmit the screen to create a CMS 1500 under print queue #2. At the end of an on-demand CMS 1500 bill creation session, all bills to all payors are printed in order on continuous CMS 1500 forms. Use the command  
**MQP<space><PRINTER #><space>2<XMIT>**  
to release the print queue and print the bills.

*Please remember that the above procedure only prints a bill. No changes are made to the patient's account receivable or the PEF history file by this procedure. Those changes have to be made separately.*

Payments received for amounts owed by other third parties may be entered using the following procedures:

1. Set up a cash target amount for the batch total dollar amount that you will be entering at one time. Use command CDS304.
2. You may review a patient's account with the command:  
**PARI<space>30<space><LOCATION><space><PAT ID><XMIT>**
3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:  
**I<space><PAYMENT><space>P<space><PAT ID><space><INV#><XMIT>**

**TO BUILD AN INSURANCE OR CONTRACT IDENTIFICATION CODE FOR BILLING (CDS351)**

Insurance or Contract Payor (I/9-C/8) – Enter billing Code 9 for an insurance company or Billing Code 8 for any other contract payor.

Code – Enter the code 001 to 8999 of the insurance company or other payor that you are building. You may use up to 8999 codes for insurance companies/policies and up to 8999 for other payors.

Contract Number – Enter the contract number that your department assigned to the contract when it was written.

Co-Pay – Enter P if there is a known percentage co-pay/per visit associated with the insurance company or policy of the insurance company. Enter F if the co-pay is a flat rate per visit.

Co-Pay Percentage – If the co-pay is a percentage of total charges, enter the percentage.

Flat Rate – If the co-pay is a flat rate per visit, enter the amount.

Company Name – Enter the Insurance Company or other third party payor name in this field. Also complete the remainder of the fields for the address.

**KENTUCKY EARLY INTERVENTION SYSTEM – KEIS BILLING (BILLING CODE #16)**

Local Health departments that participate in the KEIS may bill the Program for covered services provided to eligible children. The Central Billing and Information System manual contains specific information about billing the program. The services that are billable to the KEIS program and the approved rates are listed in the Appendices.

Correct entry of patient and service information into the Patient Services Reporting System (PSRS) will result in electronic KEIS billing on a monthly basis at the state level.

Your CBIS assigned Provider Code must be added to your HID site record. Also, your CBIS approved Provider Name must be exactly as contained in your HID site record in the PSRS. The CBIS Professional Name must be exactly as entered in the provider master record in the PSRS. Each of the KEIS service providers for your department also has a discipline code in their provider master record in the computer system. Send listings of this information to the Division of Administration and Financial Management for entry into the system.

Denied KEIS claims re-billings must be submitted to the CBIS in accordance with the procedures required by CBIS.

Payments received for amounts owed by CBIS may be entered using the following procedures:

1. Set up cash target amount for the batch total dollar amount that you will be entering at one time. Use command **CDS304<XMIT>**.

2. You may review a patient's account with command:  
**PARI<space>30<space><LOCATION><space><PAT ID><XMIT>**

3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:  
**I <space><PAYMENT><space>P<space><PAT ID><space><INV#><XMIT>**

Payments received for amounts owed by CBIS may be entered using the following procedures:

1. Set up a cash target amount for the batch total dollar amount that you will be entering at one time. Use command **CDS304<XMIT>**.

2. You may review a patient's account with command:  
**PARI<space>30<space><LOCATION><space><PAT ID><XMIT>**

3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:  
**I<space><PAYMENT><space>P<space><PAT ID><space><INV#><XMIT>**

### **PATIENT ACCOUNTS RECEIVABLE CREATION AND ADJUSTMENTS**

Individual patient's account receivables (A/R) are automatically created by the computer system for patient, Medicaid, Medicare, insurance, other third party, and KEIS billings.

1. The patient pay account receivable is created immediately upon entry of the PEF into the system. Immediate corrections to the PEF on the day of entry will also immediately correct the patient pay A/R. After the overnight posting process, corrections to the A/R must be done through screen 302 transaction procedures.
2. Medicaid, Medicare, insurance, other third party and KEIS A/Rs for each patient are automatically created as part of the monthly automated billing procedures for these payors.
3. Adjustment of patient's account due to errors or due to the write off of bad debts are made using the screen 302 transaction procedures.

### **ELECTRONIC POSTING OF PAYMENTS**

Payments from the Medicaid Preventive Program and Medicare Physicians Program are automatically posted to the patient's account. Electronic remittances from those payors are used to make the payment entries.

Errors in the electronic posting process are listed on report 580 (Medicaid), 119 (Medicare), 120 (Rail Road Medicare), 1780 (HANDS Medicaid) and 2580 (Lead Medicaid). Use the Patient A/R correction procedures and screens 304 and 302 to correct the errors.

## **IMMUNIZATION HISTORY AND REMINDER SYSTEM**

The purpose of this system is to 1) provide a complete record of a child's immunizations and 2) to notify health department personnel when a patient is due one or more of the following services: immunizations, pediatric preventive, WIC, or a combination of the three. A message will be sent to staff when scheduling patients for appointments and during patient registration notifying them of what services are due for the patient. This will assist staff by alerting them that immunization and/or pediatric preventive services may be due during the next visit, according to the records contained in the system. If the patient has an appointment already scheduled in the system for immunizations or preventive pediatric services, these reminders will not be displayed.

A critical purpose of the system is to provide a means to collect and store the history of immunizations that the child has received from either the health department or other providers.

**NOTE:** Clerical personnel **SHALL** update the patient's immunization history according to the patient chart at registration time, or encounter entry time, depending on when the chart is readily available, to have a complete record in the computer system and to avoid the system giving them false "alert" messages. Every attempt should be made to obtain immunization records for **ALL** patients receiving services at the health department and these records **SHALL** be entered into the immunization system.

### **NV CODES FOR VACCINES**

NV codes for vaccines have been added to the system to enable health departments to charge patients who are not Kentucky Vaccine Program eligible and adults for the vaccines they receive. Since the VFC vaccines are free to those who are eligible, if these codes are used when reporting vaccines for those who are not eligible, no charge is assessed for the vaccine itself. Accordingly, the vaccine codes with NV modifiers should be used for patients for whom a charge for the vaccines needs to be calculated.

NV codes work as follows:

- 1) For children with insurance or who are otherwise not eligible for VFC vaccine, there are two options. The agency may opt to allow the charge to be nominal, which will charge \$5.00 for the office visit, \$2.00 for the first vaccine administration, \$1.00 for each additional vaccine administration and the full cost of the vaccine. The other option is the fixed full charge, which will charge the patient the full cost of everything that is reported.
- 2) For vaccines which cross age lines (90714, 90718, 90658, etc.), NV codes should be reported for adults. Since adults are never VFC eligible, NV codes should be reported for adults when there is no specific code for adults for a particular vaccine. If an adult code is identified, the NV modifier is not needed. The adult vaccines may work either of two ways. If nothing is marked on the PEF to indicate that a fixed full charge is needed, the entire visit and all related codes will be charged on the sliding fee scale. If fixed full charge is marked, the patient will be charged the full cost of everything that is reported for this visit.

- 3) **REMEMBER:** If a patient is insurance eligible and the health department is billing insurance, NV codes **MUST** be used for childhood vaccines and any vaccines that cross age lines for an adult.

### **INITIAL CREATION OF IMMUNIZATION HISTORY DATA**

All past immunization/well child visits CDP has stored (dating back to 1987) will be used to create an initial immunization history file. Immunizations were recorded for patients that are currently still active, and under the age 18.

### **MAINTAINING IMMUNIZATION HISTORY DATA**

Any valid service(s) (those listed above) that are entered into the Encounter Entry screen will be automatically added to the Immunization History for the patient as they are entered. If services are added or removed using the Encounter History Maintenance function, the system will update the services (within the Immunization History) accordingly.

In order for users to add Immunizations that have been done for a patient at a location other than a local health department, an on-line function has been created. This function allows users to add or remove services and directly affect the patient's immunization history file.

### **ON-LINE FUNCTIONS AVAILABLE FOR IMMUNIZATION SYSTEM**

There are several functions available for the immunization tracking system. You can get a list of all immunizations for a patient that has been entered in the system by an encounter or through the immunization maintenance screens.

#### **Immunization History Inquiry:**

COMMAND:

**PMIH<space>Y<space>30<space><LOC><space><PATIENT ID><XMIT>**

or

**PMIH<space>30<space><LOC><space><PATIENT ID><XMIT>**

This function displays the entire Immunization history for a specific patient on your terminal. If a "Y" is entered before the client number, the inquiry is sent to queue number 12 which is visible via doing an MQI. Without the "Y" the data will be returned to the screen.

#### **Direct Entry Screen Display:**

COMMAND:

**PMIP<space>30<space><LOC><space><PATIENT ID><XMIT>**

This function will copy patient information into the Direct Entry screen and send it to the user. This screen allows the user to either add services to a patient's record, or remove services from a patient's record. The primary purpose of this screen is to allow immunizations to be entered that were done before the CDP on-line system was completed or were given at another agency.

Complete this screen as described:

**CPT**

<b><u>Left Column</u></b>	<b>Employee ID</b>	-- Required. ID of clerk entering the screen
	<b>CPT Code</b>	-- CPT code of service(s) to be added or removed
	<b>Date Received</b>	-- Required if CPT code is entered. This is the visit date when the service was provided.
	<b>Where Given (WG)</b>	-- Optional. If entered, must be "X" for another health center "L" for doctors office "O" for another agency clinic "J" for inpatient hospital "Z" for any other
	<b>Delete (DI)</b>	-- Required if you wish to delete an immunization. (If left blank will automatically add service to file.) Either a "D" or "R" will Delete/Remove the service. System will delete any CPT indicated before birth date is accessed.
	<b>IC</b>	-- "X" for Vaccines which are not routine and are administered on a different periodicity schedule.

**Center and Right CPT/Description:**

All immunizations in the history file will appear on the screen. These will come up in the center CPT code column and description. The following date column is the date that the immunization was given and the W is for where given. Validity (VR) indicates whether the service was valid or invalid. In the case where two vaccines are administered together, "V" will be displayed in the validity column if both vaccines are valid; "I" will be displayed if both vaccines are invalid; and if only one of the vaccines is valid, the first letter in the name of that vaccine will be displayed (ex.: DTP/HIB – if only DTP is valid, a "D" will be displayed in the validity column). If an extensive history exists, it will overflow into the right CPT Code/description, etc., column(s). If an immunization is invalid, it will not print on the certificate.

**USER BENEFITS**

The primary purpose is to notify health department personnel when services are due (according to the data available) for a patient when scheduling appointments and when performing the registration process.

This is accomplished via a series of different status line messages which will be highlighted in screen samples.

There will be a "weekly" off line process of scanning the immunization history file which will determine whether services are due for this patient and set up a "Message Code" file that is actually consulted during the processes of scheduling appointments and registration.

The possible messages that may display on the status line whenever it is determined that immunization and/or well child services are due consist of: IMM or WCH or IMM/WCH.

### **WIC SERVICES DUE SYSTEM**

In addition to the above messages related to Immunization and Well Child, the following messages may be displayed along with them after consulting the data available in the patient record and "WIC ACTION" history data. (At appointment entry and registration time.)

1. If patient is less than 5 years of age and not currently on WIC, the message is: "WIC=N"
2. If food instrument date is less than today's date, and the re-certification date is less than today's date, the message is: "(Recert Dt) RC OVERDUE"
3. If food instrument date is less than today's date, and the re-certification date is greater than today's date, the message is: "(FI Dt) FI OVERDUE"
4. If re-certification date is less than today's date, but the food instrument date is greater than today's date, the message is: "(Re-cert Dt) RC OVERDUE"
5. If re-certification date and food instrument date are the same month and year, the message is: "RC (Re-cert Dt)"
6. If re-certification date and food instrument date are not in the same month and year and the re-certification date is within the next three months, the message is: "FI (FI Dt) RC (Re-cert Dt)"
7. If no overdue dates, the message is: "FI (FI Dt)"

The status line messages are returned to the CRT after the registration (PSIZ or PSNM) or appointment (APIN) screen has been transmitted. A status line message may read as follows:

\*\* IMM/WCH 08/01/99 FI OVERDUE \*\*

NOTE: See the following pages for interventions which must be in place to ensure all children receiving services at the LHD are properly immunized.

## **AUTOMATIC PRINTING OF IMMUNIZATION CERTIFICATES**

Immunization certificates will include **only** immunizations that are listed on the immunization module of the system. The Immunization History Screen may be viewed by entering the command PMIH and data entered/changed by the PMIP command.

If some vaccines were received from other providers (or other local health departments) or if for some reason the immunizations given in the LHD do not appear on the immunization history, they will be on the certificate only if they have been entered into the network's immunization module. Likewise a shot received the day of the visit will show up only if the PEF has been entered into the PSRS. Immunizations provided by a health department outside your county are automatically accessible and will appear on the child's immunization history. The following commands are available when additional information is needed.

**PMIN** - Patient Name Look-up Inquiry

**PMIB** - Patient Birth Date Look-up Inquiry

**PMID** - Patient ID Look-up Inquiry

Further instructions for using these codes can be found on the following pages.

The certificates will be 8 ½ X 11 inches as printed out. A local health department stamp may be used where it says signature of physician or health department. If it is a provisional certificate you should fill in the "date valid until" (according to when the appointment for the missing dose is made or is needed). In order that school personnel may spot provisional certificates in a file, the following way of flagging shall be used; since the certificate will be filed lengthwise, please use a green marker or highlighter on the edge that is visible.

NOTE: \*\* (FOR ALL INQUIRIES) \*\*

MORE THAN ONE PATIENT MAY BE SELECTED AT A TIME. AN IMMUNIZATION SCREEN WILL BE SENT FOR EACH PATIENT SELECTED. IF A PATIENT GREATER THAN 21 YEARS OLD IS SELECTED, AN IMMUNIZATION SCREEN WITH ONLY PATIENT INFORMATION AND A MESSAGE THAT SAYS THE PATIENT IS GREATER THAN 21 YEARS OLD WILL BE SENT.

### **PATIENT NAME LOOKUP INQUIRY**

Patient Name Inquiry will give a list of patients equal to and greater than the patient name entered. The following command is used to pull up the screen:

**PMIN<space>30<space><LOC><space><PATIENT NAME><XMIT>**

### **PATIENT BIRTH DATE LOOK-UP INQUIRY**

Patient Birth Date Inquiry gives a list of patients equal to the birth date entered. Also, you can enter the last name of the patient after the birth date. This will give a list of patients equal to the birth date entered and equal to or greater than the last name entered. The following command is used to pull up the screen:

**PMIB<space>30<space><LOC><space><PATIENT BIRTH DATE (in MMDDCCYY)><space><PATIENT LAST NAME (Optional) ><XMIT>**

**PATIENT ID LOOK-UP INQUIRY**

Patient ID Inquiry gives a list of patients that are equal to the patient ID entered. If the patient ID is not found, the program will try to find the patient by the patient name. If the patient name is found the patient name inquiry screen will be sent to the user. The following command is used to pull up the screen:

**PMID<space>30<space><LOC><space><PATIENT ID><XMIT>**

## INSTRUCTIONS FOR PRINTING THE IMMUNIZATION CERTIFICATE

1. Load the printer with 8½ X 11 unlined white paper (most local health departments use this in the printer used for patient bills/receipts). Note: The patient bill/receipt does not have to be printed on two-part paper.
2. The printer needs to be set for 12 characters per inch, therefore use the **CDS108<XMIT>** or **CDS384 <XMIT>** command for the system to setup your printer. The CDS108 is to be used for all printers except the Datasouth. Complete the screen as follows:

In the first block enter Printer Number; Second block enter 88 for Page length and lines, third block enter 8 for lines per inch, fourth block enter 12 for character pitch.

For the Datasouth printer use the CDS 384 as follows: First block enter Z; second block printer number; third block 88; fourth block 12; Fifth block 1.

Do the CDS108 or CDS384 screen each morning before queuing the printer for certificates.

3. Queue the printer for the certificates through QUEUE 15. The printer must be queued each morning for printing certificates. If the certificates are to be printed on the same printer as the Bill/Receipt-both queues may be entered by simply entering the following:  
**MQP<space><Printer #><space>15<space>16<XMIT>**
4. Before printing the certificate, you may send the certificate image back to the screen to see whether corrections need to be made. To look at this image, enter the following command:  
**PMIS<space>30<space><LOC#><space><Patient ID#><XMIT>**
5. Once the Immunization History is up-to-date, including the entry of vaccines provided by outside providers or other Local Health Departments as well as those provided by the Health Department today, enter the following command:  
**PMIC<space>30<space><LOC#><space><Patient ID#><XMIT>**

A Message comes back on the screen:

**\*\*CERTIFICATE HAS BEEN SENT TO QUEUE 15\*\*.**

For quality printing, make sure the ribbon is changed frequently.

## REASON FOR VISIT CODES

Consistent with the Department for Health Services and local health departments' philosophy of patient centered health care, the reason for appointment/visit addresses broad categories of services; preventive medical, preventive counseling, other medical, other counseling, laboratory, radiology, etc.

With the combination of the visit type, as previously described, the provider type and the Cost Center, the reason for appointments and visits are further defined.

The code is made up of three subsets of codes. The first subset consists of two alpha characters for the visit type. The second subset is a single-digit code which identifies the provider type. The third subset is a two-digit code which identifies the Cost Center.

On the following page is a matrix of logical codes for reasons for appointment and visit.

The reason for visit code is used to identify the purpose of the appointment being made. If an appointment has not been made and the patient is seen without an appointment, the reason for visit is required to be entered on the registration screen. This code is used to trigger certain flags for the appointment/registration staff, e.g., patient income information is required, health checkup is due so an appointment can be made, and proof of identity, residence and income are needed for WIC certification or re-certification. Also it is necessary to know the type of provider staff to schedule.

To view a code for your site, use the following command:

**PFIA<space>30<space><HIDLOC><space><APPT REASON><XMIT>**

### REASON FOR VISIT CODES\*

800 PED/AD	802 FP	803 MAT	804 WIC	805 NUTR	806 TB	807 STD	808 KEIS	809 DIAB	810 ADULT	813 CANCER	853 HANDS	863 EPSDT	712 DENTAL
IM 200	LB202	LB303	LB304	OC405	IM306	LB107	OC308	LB309	IM210	LB113	OC353	OC483	OM172
IM300	LB302	LB503	LB504		LB306	LB207	OC408	LB509	IM310	LB213	OC953		OM372
LB300	LB502	LB903	OC304		LB506	LB307	OM308	OC309	IM910	LB313			OM572
OC400	LM202	OC303	OC404		OC306	LB507		OC409	LB310	LB513			PM172
OC900	OC302	OC403	OC904		OM106	OC307		OM209	LB510	OC313			PM572
OM100	OC402	OM103	OM204*		OM206	OC407		OM309	OC310	OC413			XR572
OM200	OM102	OM203	OM304**		OM306	OM107			OC410	OM113			
OM300	OM202	OM303	OM404**		OM906	OM207			OC910	OM213			
PC300	OM302	XR503	VP404		XR506	OM307			OM110	OM313			
PF100	PM102		VP504						OM210	PM113			
PF200	PM202		VP904						OM310	PM213			
PF300	PM302		VC304						PC310	PM313			
PM100			VC404						PF110	XR513			
PM200			VC504						PF210				
PM300			VC904						PF210				
WO800									PM110				
XR500									PM210				
									PM310				
									WO810				
									XR510				

NOTE: First two characters = VISIT TYPE. Third digit = PROVIDER TYPE. Fourth and fifth digits = COST CENTER

\* Other Reason for Visit Codes may be assigned using the combination of the listed Visit Type – Provider Type – Cost Center. The matrix is not all inclusive.

\*\*These codes are to be used only for WIC certification and re-certification visits.

**VISIT TYPE**

PM = Preventive Medical  
 IM = Immunization Visit  
 PC = Preventive Counseling  
 OM = Other Medical  
 OC = Other Counseling  
 LB = Laboratory/Pathology Services  
 XR = Radiology/Imaging  
 VP = Food Instrument (Voucher) pick-up  
 VC = VOC Transfer

**PROVIDER TYPE**

1 = Physician/Dentist  
 2 = ARNP/CNM/PA  
 3 = Nurse  
 4 = Allied Health Provider  
 5 = Lab/X-ray Tech/CMA/Dental Hyg.  
 9 = Admins./Clinic Asst./Para-Prof.

**COST CENTER**

00 = Pediatrics/Adolescent	08 = KEIS	*W0800 = DCBS Lab Specimen Collection
02 = Family Planning	09 = Diabetes	
03 = Maternity	10 = Adult Health	*W0810 = Other Lab Specimen Collection
04 = WIC	11 = Lead Screening	
05 = Nutrition	13 = Breast and Cervical Cancer	
	53 = HANDS	
06 = TB	72 = Dental	
07 = STD	PAYMT	
	CLASS	

**EDITS**

1. Visit Type PM is acceptable with Cost Centers 800, 802, 810, 813 and 712.
2. Visit Types OM, OC, VP, and VC are the only types acceptable in 804 WIC. WIC certifications and re-certifications should be either OM204, OM304 or OM404.
3. Visit Type IM is acceptable for Cost Centers 800 and 810 only.
  - \* Visit Types W0800 & W0810 will bypass registration items except Patient ID, Name, Birth Date, Sex and Race.

## **OVERVIEW OF APPOINTMENT BY PROVIDER SYSTEM**

Prior to entering patient appointments by providers, there are several foundation files that must be created in order for the actual scheduling process to begin. The files are as follows:

Calendar Record - The calendar year is established and keyed in by Custom Data Processing (CDP). The standard work days contain all starting Monday dates for previous year, current year and next year. It also contains all the statewide holidays which the system will automatically blank out when setting up a providers' schedule. CDP will set up and maintain this calendar record. To see the dates use the following command: **APIL<space>30<XMIT>**

Provider Record - Screen **CDS974<XMIT>** - Each provider or group of providers must be assigned a 2-digit code and set up as a separate record. The individual health department is responsible for setting up these codes.

Since the employee making the appointment must enter their employee number, it will be necessary to enter the name and 5-digit provider number of those employees making appointments to the employee file prior to their being able to enter and modify appointments. A security system has been set up for employees who are authorized to set up the provider's schedules. To obtain security access/clearance, the local health department director or his/her designee must present a signed request. All employees can make appointments.

Provider Schedule - Screen **CDS970<XMIT>** - Each provider must be set up with a schedule for available hours per week. These provider schedules can be set up for the next 6 months.

Once the health department has started using the appointment system by provider, do not use the CDS341 screen or the ESNM function to schedule appointments.

"Appointment by provider" must be flagged YES on HID/LOC/S Maintenance screen (CDS288) by Division of Local Health Department Operations staff.

## **HOW TO SET UP PROVIDER RECORDS**

Each provider or group of providers must be assigned a code by the local health department. Codes must be numeric from 01-99. In order to schedule appointments by provider, a record must be set up for each provider/group of providers.

Screen CDS974 is used to setup and maintain the provider codes and names and the screen will appear as follows:

Enter 30 in client field.

Enter your HID/LOC/SITE.

Enter the type of action as noted on the screen.

Enter the two-digit provider code.

Enter the initials of the first and middle name, and entire last name.

NOTE: When setting up provider codes and you would like to group providers under one provider number you may use an identifier such as nurse, RN, LPN, etc.

### **INQUIRY FOR ALL PROVIDER RECORDS**

You should run a listing of providers/provider groups to make sure they have all been entered. The last week dates need to be watched closely and extended as needed since appointments cannot be made past this date. The system will only allow appointments to be made six months from today's date. An "\*" indicates provider has been deleted. Use the following command to obtain a current list of provider records:

**APIR<space>30<space><HID/LOC/SITE><XMIT>**

### **INQUIRY FOR INDIVIDUAL PROVIDER RECORD - ALL DATES**

To get a listing of valid dates for an individual provider, the following command should be entered:

**APIR<space>30<space><HID/LOC/SITE><space><PROVIDER NUMBER><XMIT>**

### **HOW TO SET UP PROVIDER SCHEDULE**

**CDS970<XMIT>**

This screen is used only once for each provider in order to complete the initial schedule of the provider.

Once the provider record is set up, you must set up a schedule for each provider/provider group for each week with the hours the provider will be available for appointments.

A schedule can be set up for Monday thru Saturday from 7:00 a.m. - 8:45 p.m. Appointment times are established on 15-minute intervals. Each dash (-) represents 15 minutes. Each provider/provider group schedule must be established by entering dashes for each 15-minute interval which provider is not available for appointment scheduling and the number of appointments the provider/provider group can accommodate for each 15 minutes is available.

Once the schedule is entered, inquiries into the schedule may be made to see the provider schedule by week.

Instructions for completing the screen are as follows:

Client: The client number is always 30.

Enter HID/LOC/SITE the provider/provider group will be scheduled for.

- Action N - New
- C - Change
- D - Delete
- R - Reactivate

Provider Code - Enter 2-digit provider identifier. The provider # must be on file.

Beginning Date - Enter the first Monday date that the schedules will begin. This date cannot be more than 6 months from today's date and must always be a Monday date.

Weeks to Repeat - Enter the 2-digit number of weeks you wish to repeat on the particular provider's schedule. The first week will count as one of the weeks and weeks should not exceed 6 months. The week(s) that the schedule will be the same can be duplicated by entering # of weeks to repeat. Do not set up for more than one week if the schedule needs to be modified.

# APT - Enter the number of appointments, up to a maximum of nine, the provider can have for each 15-minute period. If the provider is not available enter a dash. All time slots must have an entry in APT.

NOTE: If you have a 9 in the APT column and you make 10 appointments the screen cannot show the 10 for appointments or the "X" for overbook. If you do not want staff to be able to overbook, call CDP at 502-695-1999 to place an "Overbook Block" on your system, which will allow only certain individuals to overbook on the schedule.

AREA Optional - The health department must designate the area code. Enter the area that the provider will be working in.

TYPE Optional - The health department may designate the type of appointment. Enter the type of appointment. This may be an alpha or numeric character, i.e., W could be for WIC, P for Pre-natal, S for screening, etc. When transmitting, the cursor must be at the bottom of the screen.

### **HOW TO CREATE A SCHEDULE FROM PREVIOUS SCHEDULES**

After the initial establishment screen, you can use the following function to fill in the schedule from another schedule. By changing the action, date, number of weeks, to repeat and making any schedule changes, you can transmit this screen and extend the schedule for an additional time period.

Enter the following:

**APIP<space>30<space><HID/LOC/SITE><space><DATE><space><PROVIDER#><XMIT>**

The action N is for new and will be used to extend a schedule. The action C is for change and will be used when modifying a schedule.

When extending a schedule, the beginning date must always be a Monday of a provider's schedule, if you come to a point at which you need to create additional schedules, instead of having to re-key all the data into the schedule.

When modifying a schedule, weeks to repeat can only be one week at a time. The schedule can be modified using this command; however, only a week at a time can be modified.

When using this screen to modify a schedule, make sure a listing of patients scheduled is printed out prior to modifications being made.

## **HOW TO CHANGE PROVIDER'S SCHEDULE**

To modify or set up existing schedules for provider(s)/provider groups due to sickness, meetings, etc., the operator should call up **CDS971<XMIT>** and make the changes.

Instructions for completing the screen are as follows:

Enter the **HID/LOC/SITE**

Action: Action A is entered for Available; Action N is for Not Available.

Providers - Enter the providers that need to be modified. If all Providers are to be modified, enter 999, or list all providers' numbers.

Dates - Enter the date(s) that the schedule will be modified. You can enter more than one date; be sure to leave space between these dates.

Range of Time: Enter the military time range where modifications need to be made.

NOTE: Prior to modifying a provider's existing schedule you must print out a listing of patients' schedules for the provider(s) in order to reschedule the patients' appointments. Those appointments must be voided out and re-entered after the patient has been contacted.

## **SINGLE PROVIDER INQUIRY**

Once a Provider's schedule is set up, you can do an inquiry and view the provider's schedule for a week. A Provider's schedule may be reviewed by entering the Monday's date of the week to be reviewed. A "X" in the Remn slot means there is an overbook.

NOTE: If you have a 9 in the book column and you have 10 or more patients scheduled at the same time it will only show 9 in the book column and 0 in the REMN column instead of an "X".

Enter the following:

**APIW<space>30<space><HID/LOC/SITE><space><DATE><space><PROVIDER#><XMIT>**

## **MULTIPLE PROVIDER INQUIRY**

You can also receive an inquiry for all providers for a specific date. The command is the same as that for a single provider except that provider number will not be entered. Enter:

**APIW<space>30<space><HID/LOC/SITE><space><DATE><XMIT>**

NOTE: For multiple provider inquiries you get only the schedule for the day you have requested.

## **SPECIFIC INQUIRIES BY PROVIDER**

The user may do an inquiry by type of visit if type has been defined in setting up the provider's schedule.

For a specific Type (Type must be defined in Provider's Schedule) the following command is used:

**APIW<space>30<space><HID/LOC/SITE><space><DATE><space><PROVIDER><space><TYPE><XMIT>**

### **SCHEDULING APPOINTMENTS**

Upon receiving a patient's request for a future appointment, the terminal operator will enter the following command:

**APIN<space>30<space><COUNTY CODE><space><Patient ID #><XMIT>**  
or **APIN<space>30<space><COUNTY CODE><space><Patient Name><XMIT>**

If this entry results in either an exact match on patient name or patient ID, the appointment entry screen will be returned for the operator to complete.

If an exact match is not found when a patient ID number is used, a screen will return so that the patient's name can be entered. If an exact match is not found when a patient's name is used, a list of names that is at least as far along in the alphabet as the name that was keyed in will be displayed. If the correct name is listed, the operator should place the cursor to the left of the name and key in an "X". The operator should then transmit the screen, which will then result in the appointment screen being returned.

If the correct name is not listed, an "A" should be entered to the left side of the top line, which is blank, and the screen transmitted. Another screen will be returned containing appointment names not in file look-up. If the patient's name is not on the list, an "X" should be placed on the top line and the screen should be transmitted. The appointment screen will be returned for the operator to complete.

All information on the Appointment Screen will transfer to the Registration Screen.

If there is more than one exact hit on the name, the following screen is returned with the patient ID number and birth date for each patient.

The operator should place a "X" by the patient with the correct ID number and birth date and transmit. The appointment screen will then be displayed.

The data to be entered is:

**HID/LOC/SITE:** The system will automatically place the HID/LOC/SITE in the appointment record. If there are multiple sites within a district, you must enter an alpha/numeric suffix for the site for new patients.

**Exist Flag:** If patient is on file "Y" will be filled in; "N" will appear if the patient is not on file.  
**Patient Identification Number:** Will be filled in for patients on file; for patients not on file, fill in with social security number or pseudo number.

**Appt No Home Contact:** Applicable only to Fayette County.

**Special Elig:** Applicable only to Fayette County.

**Patient Name:** Enter first, middle initial and last name.

**Birth:** Enter patient's date of birth.

**WCO:** WIC other (is a y/n field, if yes, it means child is getting WIC benefits from another source).

**NEL:** Not eligible for WIC, is a y/n field.

**Address:** Enter patient's address.

**City, State, Zip:** Enter city, state, zip code.

**Phone Number:** Enter patient's phone number if possible.

**Book Override:** This is set up by CDP and has to do with overbooking.

**INIT CNT:** The date that the patient was initially contacted for the WIC program.

**LFUCG #:** Only applicable to Fayette County.

**Action:** Enter action code (listed on screen).

**Date:** Enter appointment date.

**Time:** If scheduling by provider, leave blank and the provider schedule will be returned to complete scheduling.

**Provider:** If provider is known, enter the provider. If specific provider number is not entered, schedule screen will be returned for all providers for the specified date. If the Provider number is entered and the time is left blank, the scheduling screen will be returned for the whole week for the provider entered.

**Length:** If this field is left blank the system will pull length from the service file. The service file is 0 unless the LHD has called in with a specified time. If screen is blank and no time is specified on the service record, it will default to 15 minutes.

**Type:** If scheduling screen is returned, will only show the available times for the specified type.

**Area:** If scheduling screen is returned, will only show the times for the specified area.

**Reason For Appointment:** First service is required for all appointments. The last three are optional. Put the service for which the patient is primarily being seen first.

**NOTE:** It is important for system accuracy that the services expected field be filled in as correctly and completely as possible. Much of the billing system depends on these codes for proper functions and editing.

**Labels/Date:** Will pull up address and Medical Record labels on all patients. If needed, you may also pull up appointment labels from this screen by entering the number of appointment labels needed in the label block marked "A".

**Next Patient Name:** Can specify the next patient ID or name to be scheduled. This can only be used if the provider scheduling screen is not pulled up.

**Clerk:** Enter employee ID number.

**HH Screen:** Enter "X" or "Y" if household screen is needed.

**NOTE:** After you have transmitted the scheduling screen, if you did not enter the time, another scheduling screen will be returned and the appointment should be completed from that screen. If the provider's number was entered, the screen will have the provider(s) schedule for the week. If no provider was specified you will get a list of all the providers available for that particular date. If the area and/or type was entered, only those available time slots for the area/type will be shown. If the appointment is a Saturday date leave the provider number blank on this screen also and the system will then pull up Saturday's schedule.

The screen for a single provider provides the number of appointments booked, the number remaining, area and type of appointment. To schedule the appointment, put in the time. If there is not a possible time slot, blank out the appointment date and provider number and put in the alternate date and alternate provider number in the fields listed. The screen will be returned with the new week and allow you to enter the desired time and provider. If an "X" appears in the Remn appointment field that means you have overbooked. To have an overbook block placed on your appointment system, contact CDP at 502-695-1999.

The multiple provider screen shows the remaining appointments and the types. Put in the provider number and time. If no time slots are available to schedule the appointment, blank out the appointment date and put another date in the alternate date field. A new screen will be returned.

NOTE: The label types mentioned previously may be pulled from this screen also.

### **NEXT AVAILABLE APPOINTMENT INQUIRY**

The Appointment System has been modified so that the user can do inquiries to determine the next available appointment. This can be done for a particular provider or for all the providers at your site.

In order to do this inquiry, the user must first bring up the appointment setup screen. This can be accomplished by doing the APIN function.

The user should enter an "L" in the action field and a reason for visit. The user may also enter the date and/or the provider. The date and provider are optional.

If the user only enters the action “L” and a reason for visit, the system, starting with today’s date, will search through the providers looking for available appointments. If the system locates providers that have open appointments for today, it will return a list containing all the providers who still have appointments open. If all the appointments are filled for today, the system moves on to the next day. The system will continue this cycle until it locates a provider with open appointments.

If the user enters the action “L”, a provider number and a reason for visit, the system, starting with today’s date will locate the first day that appointments are available for the provider entered. Once an open appointment has been located for the particular provider, the system will return the entire week’s schedule.

If the user enters the action “L” a date and reason for visit, the system, starting with the date entered will search through the providers looking for available appointments. If the system locates providers that have open appointments for the date entered, a list containing all the providers with open appointments will be returned. If all the appointments are filled for the date entered, the system will move on to the next date. The system will continue this cycle until it locates a date with open appointments.

If the user enters the action “L”, a date, provider and a reason for visit, the system, starting with the date entered, will try and locate an available appointment for the date and provider entered. Once an open appointment has been located for the particular provider, the system will return the entire weeks schedule. If the system is unable to find an open appointment for the date entered, it will move on to the next day.

NOTE: Due to the time involved in locating the next available appointment, the system will only maintain the next 20 available dates for a provider. However, as schedules are filled, existing schedules are updated, and new schedules are set up, these 20 dates will be updated continuously. If the user enters a date which is outside the next available date, the system will return the following message:  
“DATE OUTSIDE NEXT AVAILABLE DATE RANGE”.

### **DAY 32 PROCEDURES**

The appointment system will only allow provider schedules 6 months in advance from today’s date. For return visits outside this 6-month period, you can use Day 32 as a reminder. On the appointment system, enter the month and year you need to see the patient and the day will be 32. Ex. 10322000. The provider is an optional field when setting up day 32. The appointment schedule functions all work with day 32 (POIE, POIX, POIA, CDS288). The process should be set up so that at any time, a listing can be printed of all your day 32 appointments for the current month. With your listing, contact the patient and schedule a valid appointment.

### **CONSOLIDATED LISTING OF PATIENT APPOINTMENTS**

The user has the ability to call out several different schedules at any time throughout the day. To obtain a listing of all the patients scheduled for a specific day, the following should be used:  
**POIE<space>30<space><HID/LOC/SITE><space><DATE><space>ALL<XMIT>**

### **OPTIONS - A (AREA); T (TYPE); P (PROVIDER)**

NOTE: This report is sent to printer queue 10 and the queue must be opened in order for the report to print.

To obtain a listing of all appointments within a range of time for any day enter:

**POIX<space>30<space><HID/LOC/SITE><space><DATE><space><FROM TIME TO TIME><XMIT>**

**OPTIONS - A (AREA); T (TYPE); P (PROVIDER)**

The specific Cost Center is also available and is called out through entering:

**POIE<space>30<space><HID/LOC/SITE><space><DATE><space><COST CENTER><XMIT>**

**OPTIONS - A (AREA); T (TYPE); P (PROVIDER)**

NOTE: This report is sent to printer queue 10 and the queue must be opened up in order for the report to print.

To obtain a listing of appointments by individual providers, (1 provider per page) the following command should be used:

**POIA<space>30<space><HID/LOC/SITE ><space><DATE><XMIT>**

After this command has been transmitted operator will get the STATUS LINE MESSAGE **\*\*Your Job will be processed shortly\*\***; **\*Job has been submitted\***. The user should then call out and print Report 905 by using **CDS3<XMIT>**.

Sample reports obtained from these commands are at the back of this section.

### **OBTAIN CHART PULL LISTING**

This listing is used to pull medical records of patients with scheduled appointments and to print labels. The operator may obtain up to five (5) dates of scheduled appointments at one time.

Dates cannot exceed two (2) weeks from the date entered. This listing may be obtained in numeric or alpha sequence. These reports cannot be requested immediately, they are generated overnight. The operator should enter the following: **CDS288<XMIT>**

The operator should complete only the top part of the screen.

### **COMMAND:**

**Client Field - 30**

**Action - C**

**HID/LOC/SITE – your HID/LOC/SITE**

**Labels/Patient - Number of labels per patient, you may enter 1 - 9.**

**Chart # Seq - Y for listing by the medical record #, N if you want alpha listing.**

**Labels (1 or 2 across) - 1 for single roll of labels, 2 for 2 across labels.**

**Dates to Pull - dates of scheduled appointments you want to be printed.**

**Chart Pull Rpt Ar To Split - if you want these split out by Reporting Area.**

**<XMIT>**

After the CDS288 screen is transmitted, the operator should review the information to ensure pull dates are correct. To review, enter the following command:

**PSIL<space>30<space><HID/LOC/SITE><XMIT>**

To obtain requested listing and/or labels - user must call out and print Report 300 Pull Listing and/or Report 301 Labels the next working day.

### **NAME LOOK-UP OF PATIENT'S WHO ARE NOT ON PATIENT FILE**

An inquiry may be done on a patient who has an appointment but does not have a record in the patient files. The following command should be entered.

**APIO<space>30<space><COUNTY CODE><space><PATIENT NAME><XMIT>**

*EXAMPLE:* APIO 30 500 JOHN T GIGGY<XMIT>

By placing an "X" beside the name, the patient's appointment screen will be displayed showing the appointment date, time, etc. If the patient is not on file, place an " X " on the top line, and a blank appointment screen will be displayed for you to complete.

### **MISSED APPOINTMENT LIST AND LABELS**

Health departments may obtain a missed appointment list daily. If you wish to have this report printed at your health department, contact the Help Desk at (502) 564-7213 or CRT 2168 and request that Report 865 be run for your site. You may also request Report 864 which will print labels for use in contacting these patients. The reports are run nightly for appointments missed on the previous day.

### **AUTO DIALER SYSTEM**

Health Departments may use the autodialer software for reminding patients of appointments. To download phone messages for dialing reminder messages, see the WIC PROGRAM section in VOLUME II of this ADMINISTRATIVE REFERENCE, for Auto Dialer Download instructions.

If you are having problems with the Auto Dialer system, contact the state WIC office at: (502) 564-3827 or via CRTS 2221 or 2222.

# **PAP TEST AND MAMMOGRAM RESULTS REPORTING**

## PAP TEST RESULTS REPORTING

When the CPT Codes 88164 or 88142 are entered from the PEF it will be posted to the patients encounter record and will go on the Pap Log in a pending status until the results are entered. Once the results are received from the Lab (reviewed and coded by the nurse) the support staff will enter the results in the Results Pending Screen as follows:

**PERS<space><30><space><County Code><space><Patient ID Number><space><88164 or 88142><space><Date Pap Test Collected><XMIT>**

The Results Pending screen will come back with a space for the result code and the date the result was collected by the LHDs. Fill in the screen with the result code (see code list below) and the date collected in the 6-digit format (Mo, Day, Yr).

### **Category Explanation**

- # 1 NEGATIVE FOR INTRAEPITHELIAL LESION AND NEGATIVE FOR INTRAEPITHELIAL LESION WITH PRESENCE OF ORGANISMS OR REACTIVE CELLULAR CHANGES
- # 2 ATYPICAL SQUAMOUS CELLS OF UNDETERMINED SIGNIFICANCE (ASC-US)
- # 3 ATYPICAL SQUAMOUS CELLS CANNOT RULE OUT HIGH GRADE (ASC-H)
- # 4 LOW GRADE INTRAEPITHELIAL NEOPLASIA (CIN I, Mild dysplasia, HPV) (LSIL)
- # 5 HIGH GRADE INTRAEPITHELIAL NEOPLASIA (CIN II, CIN III, Moderate Severe Dysplasia, and Carcinoma In Situ) (HSIL)
- # 6 SQUAMOUS CELL CARCINOMA
- # 7 OTHER – DESCRIBE, INCLUDES ADENOCARCINOMA OR ADENOMA CARCINOMA-IN-SITU
- # 8 UNSATISFACTORY – Repeat between 8–12 weeks.
- # 9 ABNORMAL GLANDULAR CELLS OF UNDETERMINED SIGNIFICANCE (AGC), ATYPICAL GLANDULAR, ATYPICAL ENDOCERVICAL, ATYPICAL ENDOMETRIAL

NOTE: Pap Tests, which are not paid for by the LHD, are to be reported on the Supplemental System. See the Supplemental Reporting System Section of the manual for instructions on reporting results of these Paps.

## MAMMOGRAM RESULTS REPORTING

Since most mammograms are provided at a location other than the LHD, the ACH-16 Form must be received before the bill is paid and the PEF entered. The ACH-16 is the result report from the Radiologist. Upon receipt of the ACH-16, and after the nurse makes sure the ACH-16 and the mammography report agree, the mammography results must be entered in the KWCS Data Collection screen. When the bill is received, the mammogram service is to be recorded on the PEF and entered into the system. If the result entered in the PEF does not match the result entered in the KWCS Data Collection screen, an error message will be displayed. In this case, verify the result with the nurse or Nurse Case Manager before making any correction of the mammogram result data on the KWCS screen to match the result entered in the PEF. It is imperative that the correct results are reported for the screening mammography in the KWCS Data Collection screen and the PEF. CPT Codes 77055, 77056, and 77057 require one of the codes 0-6 be entered in the primary diagnosis field in the override area preceded with an "R". Modifier codes 26 and TC are entered in the PEF for each of these CPT codes; however, enter the codes 0-6 only for the 26 modifier, not for the TC modifier. The ACH-16 is not required for follow-up of 77057. If the mammogram is provided by a mobile unit, the mammogram CPT of 77055, 77056 or 77057 may be reported without the result. The mammogram will get posted to the mammogram log in pending status awaiting the results.

The mammogram CPT codes listed above must have an 80000 HDPT/CPT code listed/entered first on the same PEF. The 80000 code must have a valid ICD which will tell the system the reason for the mammogram.

The Primary ICD Code to use with the 80000 Code for the CPT 77057 Screening Mammogram is V7619; the 77055 and 77056 are to be reported with one of the billable ICD codes 611.72 or 611.79.

The one-digit result codes to be reported on the same line as the 77055, 77056 and 77057 are as follows:

The codes for mammograms are as follows:

<u>RESULT CODE</u>	<u>DEFINITION</u>
0	Assessment Is Incomplete
1	Negative
2	Benign Finding
3	Probably Benign
4	Suspicious Abnormality
5	Highly Suggestive Of Malignancy
6	Known Biopsy-Proven Malignancy

**NOTE:** Mammograms which are not paid for by the LHD are to be reported on the Supplemental System. See the Supplemental Reporting System Section of the manual for instructions on reporting results of these mammograms. You will not have a KWCS Data Collection Screen for these patients.

# **PATIENT SERVICES / SUPPLEMENTAL REPORTING**

**You can access this form on the CDP  
web site and copy as needed:**

<https://www.customdatainc.com/downloads.asp>

# **PATIENT SERVICES SUPPLEMENTAL REPORTING FORM (CH-47)**

## **SUPPLEMENTAL SERVICES REPORTING OVERVIEW**

The Patient Services Supplemental Reporting System collects and stores patient services data which are not reported through the Patient Encounter Form. Such data include face-to-face encounters as well as other patient services which the health department does not provide directly or does not pay, e.g. services for Medicaid patients, those with insurance or other third party which the providing agency bills rather than the health department. Also reported will be activities such as case management, maternity education class attendance and resource person activities. KEIS, EPSDT verbal notification and HANDS services are recorded and billed through this system. There are 100 service codes (900-999) which may be assigned and used at the discretion of the health departments. Note: Pediatric Outreach/Follow-up, Cancer Outreach and EPSDT Outreach have been removed from the supplemental form. However, if your health department would like to continue to count these activities, you may use the codes 900 through 999 designated for discretionary use to track these services.

This data is collected on the Patient Services Supplemental Reporting Form. It is entered and stored on a separate computer file but is linked through the patient identification number.

If a patient record created from a patient encounter form (PEF) exists on the system, the patient data will be linked with the patient identification number.

**FORM CH-47**

**Top portion of form contains patient demographics- see field definitions in HOW TO BUILD/UPDATE A SUPPLEMENTAL REPORTING RECORD AND SERVICE DEFINITIONS.**

**WIC NUTRITION EDUCATION CLASS (804):**

<u>SERVICE CODE</u>	<u>DEFINITION</u>
31	WIC Nutrition Education Class Attendance (45 minutes)
32	WIC Breastfeeding Education Class Attendance (45 minutes)
33	Kiosk Nutrition Education

**OTHER NUTR ED (805):**

<u>SERVICE CODE</u>	<u>DEFINITION</u>
36	Other Nutrition Education Class Attendance (45 minutes)
37	Nutrition Education to a Caregiver (Other than WIC)

**CANCER (When Provider Bills Medicaid or Other Third Party) (813):**

**The services will be documented in the Medical Record.** The ONLY mammograms and paps that are to be reported here are the ones who have Medicaid/Medicare or other third party (OTP) payment and the provider bills for these services instead of the Health Department.

<u>SERVICE CODE</u>	<u>DEFINITION</u>
56	Screening mammogram for LHD patient when the provider bills Medicaid/Medicare or other third party.
57	Diagnostic mammogram for LHD patient when the provider bills Medicaid/Medicare or other third party.
58	Pap Smear for LHD patient when lab bills Medicaid/Medicare or other third party.

Enter the one-digit code that identifies the result of the mammogram.

<u>BiRads</u> <u>CATEGORY</u>	<u>DEFINITION</u>
0	Assessment Incomplete – need additional imaging evaluation
1	Negative
2	Benign Finding
3	Probably Benign – short interval follow-up indicated
4	Suspicious Abnormality
5	Highly Suggestive Of Malignancy
6	Unsatisfactory for interpretation – need repeating

Enter the one-digit code that identifies the result of the pap.

<u>CATEGORY</u>	<u>DEFINITION</u>
-----------------	-------------------

- # 1           NEGATIVE FOR INTRAEPITHELIAL LESION AND  
NEGATIVE FOR INTRAEPITHELIAL LESION WITH  
PRESENCE OF ORGANISMS OR REACTIVE CELLULAR  
CHANGES
  
- # 2           ATYPICAL SQUAMOUS CELLS OF UNDETERMINED  
SIGNIFICANCE (ASC-US)
  
- # 3           ATYPICAL SQUAMOUS CELLS CANNOT RULE OUT HIGH  
GRADE (ASC-H)
  
- # 4           LOW GRADE INTRAEPITHELIAL NEOPLASIA (CIN I, Mild  
dysplasia, HPV)
  
- # 5           HIGH GRADE INTRAEPITHELIAL NEOPLASIA (CIN I, CIN  
II, Moderate-Severe dysplasia, or carcinoma-in-situ.
  
- # 6           SQUAMOUS CELL CARCINOMA.
  
- # 7           ADENOCARCINOMA OR ADENONOMA CARCINOMA-IN-SITU.
  
- # 8           UNSATISFACTORY – Repeat between 8-12 weeks.
  
- # 9           ATYPICAL GLANDULAR CELLS OF UNDETERMINED  
SIGNIFICANCE (AGUS).

NOTE: Pap Smears, which are not paid for by the LHD, are to be reported on the Supplemental System. See [“Supplemental Services Reporting Overview”](#) for instructions on reporting results of these paps.

**MEDICAID TREATMENT FUNDS (BCCTP) (813):**

<u>SERVICE CODE</u>	<u>DEFINITION</u>
213	Precancerous Breast Conditions
214	Cancerous Breast Conditions
215	Precancerous Cervical Conditions
216	Cancerous Cervical Conditions

**COMPREHENSIVE MATERNITY (803):**

These codes are used for deliveries for which the physicians have billed Medicaid or other third party directly. For all Prenatal Patient services listed below you are required to have documentation in the medical record. Upon receipt of documentation of delivery or miscarriage the Supplemental Reporting Form should be completed.

<u>SERVICE CODE</u>	<u>DEFINITION</u>
70	Comprehensive Maternity Visit.
71	Vaginal delivery by provider who bills Medicaid or other third party.

- 72 C-Section delivery by provider who bills Medicaid or other third party.
- 73 Treatment for miscarriage by provider who bills Medicaid or other third party.

**KEIS (808):**

First Steps, Kentucky Early Intervention System ([KEIS](#)), an expansion of the Federal [“Individuals with Disabilities Education Act”](#) is aimed at reaching and identifying children age birth to three (3) with developmental disabilities. First Steps seeks to provide family centered and community-based evaluation, assessment, services planning and coordination at no cost to families regardless of income. Provider participation in KEIS requires certain data to be maintained as part of the child’s early intervention record. These data must be collected and maintained electronically in order for the provider to receive reimbursement for services to eligible children and their families. The following KEIS service codes are reportable only in the supplemental system:

<u>SERVICE CODE</u>	<u>DEFINITION</u>
X0076A	Primary Service Coordination (Office)
X0076B	Primary Service Coordination (Home)
X0064A	Initial Service Coordination (Office)
X0064B	Initial Service Coordination (Home)
X0058A	Collateral Services (Office)
X0058B	Collateral Services (Home)
X0011	Primary Evaluation
X0050C	Therapeutic Code Treatment (Office)
X0060	Therapeutic Code Treatment (Home)

**HANDS/MEDICAID BILLING (853):**

<u>SERVICE CODE</u>	<u>DEFINITION</u>
T1023	Assessment
S9444	Home Visit (Paraprofessional)
S9445	Home Visit (Professional)

The HANDS 2-digit Referral Codes are to be reported as applicable in the “Referral/ Specimen” area at the bottom of the form

75 Substance Abuse	79 Physician	83 Education	87 Health Department
76 Mental Health	80 Domestic Violence	84 Transportation	88 Smoking Cessation
77 Basic Needs	81 Other	85 Child Care	89 Oral Health
78 First Steps	82 N/A	86 Employment	

**FLUORIDE (not face-to-face) (800):**

The fluoride program is primarily for pre-school children (6 months – 6 years) who are not presently receiving fluoridated drinking water, other fluoride supplements, or vitamins with fluoride. Whether or not a child is receiving fluoride can be determined by the answers to questions on the questionnaire and consent form (OH-9).

For patients with abnormal fluoride test results from water samples submitted to the State Lab, issuing of fluoride supplements (drops or tablets) and follow-up should be followed per protocol. If the test results from the water sample are  $\geq 2.0$  ppm, call the Oral Health Program Administrator at 502-564-3246 for further clarifications and directions.

**FLUORIDE SUPPLEMENTS** – Fluoride supplements given when patient is not in the clinic (e.g. mother picks up the supplement for child) should be reported in the supplemental system using the following codes:

<u>SERVICE CODE</u>	<u>DEFINITION</u>
S0001	Fluoride Drops 1 <sup>st</sup> dose
S0002	Fluoride Drops Refill
S0003	Fluoride Tablets 1 <sup>st</sup> dose
S0004	Fluoride Tablets Refill

**FLUORIDE WATER TESTING** – Water samples tested for fluoride content should be reported in the supplemental system using the following code:

<u>SERVICE CODE</u>	<u>DEFINITION</u>
S0009	Fluoride Water Testing

*Type of water specimen should be reported using one of the following codes:*

<u>SPECIMEN CODE</u>	<u>TYPE OF WATER SPECIMEN</u>
31	Well Water (Denote well depth)
32	Cistern Water
33	City Water
34	Bottled Water
37	Other

**MOMMY AND ME CODES:**

<u>SERVICE CODE</u>	<u>DEFINITION</u>
99510	Prenatal Nursing Visit
99501	Postpartum Nursing Visit
99441	Prenatal Phone Call
99442	Postpartum Phone Call

**LEAD TEST** (When provider bills Medicaid or OTP) (800, 803, 810)

<u>SERVICE CODE</u>	<u>DEFINITION</u>
L01	Lead Test Pediatric
L02	Lead Test Maternity
L03	Lead Test Adult Health (age 16 years or older)

**LHD DISCRETIONARY Codes – 900 through 999**

### **ENTERING SUPPLEMENTAL FORM:**

When entering supplemental service data, if the patient has a PEF record, the name, birth date, sex, and race fields do not need to be completed. These fields will be filled in on the screen by the computer. If a PEF record does not exist, but a supplemental record does exist, the entry screen will be filled in with patient's name, birth date, sex, and race for subsequent supplemental record entries.

Patient master records are now created in the supplemental system and these records will be interfaced with the PEF system. A patient with a supplemental record will be accessed to pull common demographic data to the PEF system.

There are five commands for computer screens for the supplemental reporting component of the system. The following pages contain instructions for using these screens.

### **HOW TO LOCATE THE PATIENT BY ID #:**

The user must first determine if the patient has a record in the patient encounter system or the supplemental system. The patient is indexed in the system by identification number and name. The user should do an inquiry by ID # and name prior to entering data on the screen to avoid duplication.

### **TO LOCATE A PATIENT BY PATIENT ID # THE FOLLOWING COMMAND SHOULD BE ENTERED:**

**CMIP<space>30<space><LOC><space><PATIENT ID NUMBER><XMIT>**

The system will search the files for patient ID #. If the ID # is found, the Services Reporting Screen will be returned to enter data. Note that certain fields will be filled in with information that was entered previously on a PEF or a Supplemental Form. Those fields must be updated with the information noted on the Supplemental Reporting Form. **Note: By updating the fields, the patient record will be updated the same as updating on the patient maintenance file.**

If the patient's ID # was not found, the system will automatically display a name look-up.

The system will search for the patient's name. If the patient's name is identified, the Supplemental Reporting Screen will be displayed to enter the service.

If the patient's complete name is not identified, the system will automatically display the names in the alphabet closest to the name keyed.

If the patient's name is not listed on the name look-up, place an "X" in the bracket on the blank line and transmit. The Supplemental Reporting Screen will be displayed with the HID location, ID number, and name. Complete the screen.

After completion of the screen, transmit for entry into the system.

## HOW TO LOCATE THE PATIENT BY NAME:

To locate the patient by name, the following command should be entered:  
**CMNM<space>30<space><LOC><space><PATIENT NAME><XMIT>**

The system will search the files for the patient's name and the name look-up screen will be displayed. If the patient's name is listed, the user should place an "X" before the name and transmit. If the Supplemental Reporting Screen is returned, note that certain fields will be filled in with information that was entered previously on a PEF or a Supplemental Reporting Form. Now complete and/or update the screen as necessary.

If the patient's name does not appear on the name look-up list, an "X" should be placed in the bracket by the blank line. The Supplemental Reporting Screen will be displayed with HID location and name. Complete the screen.

NOTE: If the patient's name is listed twice on the name look-up screen, the operator will have to determine which one is the correct person. The CMNM command should be entered again using the complete name, including middle initial of the patient. Once this command is transmitted, the duplicate names showing ID number and date of birth will be displayed for you to select from.

By placing an "X" before an ID number, the system will display a Supplemental Reporting Screen for completion.

## HOW TO BUILD/UPDATE A SUPPLEMENTAL REPORTING RECORD AND SERVICE DEFINITIONS

Illustration of a patient who has had a previous supplemental reporting or PEF encounter. Fields pertaining to the service must be updated.

Following are instructions for entering supplemental data on the computer screen and to print a label to be placed on the supplemental reporting form. Make sure you have queued your printer for labels.

- CLIENT:** Will always be 30.
- ACTN:** If entering services for the first time the system automatically places an "N" for new. On subsequent visits a "C" will appear. To delete a document, enter a "D," or to reactivate enter a "R."
- HID/LOC/SITE:** The HID/LOC will be displayed on the screen. If there are multiple sites within a district, enter the alpha suffix for the site.
- PATIENT ID/  
MDCD#** If the patient already has an ID number in the system, it will not be necessary to re-enter. If the patient's ID number is not brought forward to the screen, enter patient's identification number.

This number is the primary means of identifying and counting patients. Accurately recording the same patient number on every visit is important. The patient's ID number is his/her Social Security or pseudo number. It is no longer the Medicaid number. For instructions on assigning pseudo numbers, see registration section. **If the ID number is different from what is in the system, change the number (by using the PCKK command) before you enter services.**

**MEDICAID #** If the patient's Medicaid number is not brought forward to the screen, enter the patient's Medicaid number. Patients who have applied or are potentially eligible (A) for Medicaid will not have an entry in this field until the Medicaid number is assigned. Presumptively eligible Medicaid clients will be assigned a number on the day they apply (E).

**DOCUMENT #:** The system will automatically assign the document number.

**PLACE OF SERVICE:** If service is provided at the health department, leave this block blank. Enter the one-digit alpha code for place of service.  
Valid places of service are as follows: J - Inpatient Hospital  
M - Patient's Home  
K - Outpatient Hospital  
L - Physician's Office  
O - Other

**Contact Date:** Enter the date of the contact by entering the six-digit number in month-day-year order, i.e., 04102000.

**\* If a patient record already exists in the system these items will automatically update the screen:**

1. Patient Name (L,F,M)\* - Enter patient's last name. Do not use apostrophes, periods, commas, or any other special characters or symbols. Up to 17 alpha characters may be used. First name and M.I. - Enter the patient's first name and middle initial. Up to 12 alpha characters may be entered for first name, one character for middle initial. Special characters or symbols as listed above should not be used in this field.
2. Home Phone # - Enter the area code and phone number of the patient/parent/caretaker.
3. Name Of Parent/Caretaker (F,M,L) - (If different from patient.) Enter the last name, first name, and middle initial of the parent/caretaker. Up to 17 alpha characters may be used in last name and 12 for first name.
4. M/Caid\* - Enter (Y) if eligible; (N) no; (A) applied/potentially eligible; (M) mother; (K) K-CHIP III; or (E) Presumptively Eligible (Prenatals only).
5. E Beg DT - Medicaid eligibility begin date.
6. M/A Part # - Enter Managed Care Partnership number.
7. Member # - Enter patient's member number assigned by Managed Care Partnership.
8. AuthRef - Enter authorization number (authorized by Managed Care Partnership).
9. Prim Health Prov - This item is designed to be used to identify the primary health care provider. Up to 9 codes are open. The Codes will be assigned at a later date.
10. Medicare Eligible - Enter Y if eligible.

11. Mdcr # - Enter patient's Medicare #.  
CBIS # - Enter patient's CBIS #.
12. KTAP\* - Enter a (Y) yes or (N) no to indicate if benefits are/are not being received.
13. Food Stamps - Enter a (Y) yes, (N) no to indicate if the patient or family member is/is not receiving food stamps.
14. Race/Ethnicity\* - Check all races as self-declared by the patient. Explain that this information is collected for reporting purposes and has no effect on any eligibility.
  - **W** (White) – A person having origins in any of the original peoples of Europe, Middle East, or North Africa.
  - **B** (Black or African American) – A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”
  - **N** (American Indian or Alaska Native) – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachments.
  - **A** (Asian) – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
  - **H** (Native Hawaiian or Other Pacific Islander) – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**His/Lat (Hispanic/Latino):**

Enter “Y” (yes) or “N” (no) for the patient's self-declared ethnicity for Hispanic or Latino. Hispanic or Latino is a person of Cuban, Mexican, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”

15. Sex\* - Enter (F) for Female or (M) Male.
16. Birth Dt\* - Enter the patient's date of birth using the following format: month/day/century/year. i.e. 05051993
17. Med Rec # - For those health departments which have a numeric record system. Entry format depends on local definitions. Up to eight numeric spaces are allowed in this field.
18. HANDS Family ID # - HANDS assigned family ID #.
19. Service Cd - Enter the appropriate service code.
20. Units – Some services will be reported in units. Up to 99 units are acceptable to the system.
21. Result – Enter the one-digit code that identifies the result of the pap or mammogram.
22. Provider Id # - Enter the five character provider class ID number of the health department employee providing the service.
23. Ref/Spec. Code - If a referral is made, enter the appropriate referral code from the following list. Up to 3 referral codes are allowed. For Fluoride Water Testing, the source of the water sample must be entered here. See supplemental form instructions for applicable codes.
24. Next Appt Date - Enter the next date of appointment.

25. # of Labels - Enter the number of labels to print. Place the label on the upper left corner of the form.
26. Next patient ID #. To enter data in the supplemental system for another patient, enter the patient's I.D. number and transmit.

After the information has been entered, transmit the screen. A status line message will be received indicating that the record has been built, the document number will be displayed, and a label will be printed. Place the label on the upper left-hand corner of the form. (If Fluoride Water Testing (S0009) has been reported, a water specimen label will be printed - place the label on specimen tube.)

#### **SUPPLEMENTAL CODING NAME LOOK-UP INQUIRY:**

If an encounter has been entered, the patient's name, DOB, ID #, race, and sex will be listed on the name look-up listing. This screen will display patients in alphabetical order. Remember the names on this list will only be patients who have had a previous supplemental or PEF coding encounter entered.

#### **TO LOCATE A PATIENT ON THE NAME LOOK-UP, ENTER THE FOLLOWING COMMAND:**

**CMIL<space>30<LOC><space><PATIENT ID #><XMIT>**

If you need to look at a document you previously entered, an "X" should be placed in the bracket by the document number and the record for that visit will be displayed. If an error has been made in keying the type of service, a change can be made. The only things you cannot change are the document number and patient ID number.

After changes are made and transmitted, you will get a status line message indicating that the document number has been changed.

#### **LISTING OF MULTIPLE DOCUMENTS ON A PATIENT:**

This inquiry will give you a listing of the documents the patient had on file by entering the following command. This list could be used to make corrections on individual documents or to assist you in verifying previous services.

**CMIL<space>30<LOC><space><PATIENT ID #><XMIT>**

A listing of documents will be displayed. Place an "X" in bracket before the document you would like to review.

#### **PATIENT INQUIRY BY DOCUMENT NUMBER:**

The user may call up an individual document by entering the following command:

**CMID<space>30<space><HID/LOC/S><space><DOCUMENT #><XMIT>**

**NOTE: EACH TIME THE USER TRANSMITS THE PATIENT SERVICES/  
SUPPLEMENTAL REPORTING SCREEN, A NEW DOCUMENT NUMBER WILL**

BE ASSIGNED BY THE SYSTEM. Therefore, DO NOT RE-TRANSMIT in the event the printer fails to print the label to your satisfaction. User must go to another page of the CRT and enter the CMID command and print the label from that screen.

If duplicate document number(s) are assigned for supplemental service(s), the user must delete the invalid number(s). To delete a document, change the action field to delete (D).

## **PROCEDURES FOR USING THE SUPPLEMENTAL SYSTEM TO REPORT ATTENDING GROUP SESSIONS HELD IN THE CLINIC**

1. Register the patient through the regular registration process. If the only service the patient is to receive is the group education, only a supplemental form will be completed and entered into the system. A master may be built for these in the supplemental system.
2. If PEF services are also provided, register the patient as usual and print a PEF label. Record the regular service (CPTs/HCPTS) on the PEF.

Complete the supplemental form. Only the service code and provider number will be necessary for the group services provided in the clinic.

At check-out, when the PEF is entered; there will be a flag on the PEF screen to request the supplemental screen. The only data necessary to complete the supplemental screen will be the service code and provider. A supplemental label will be printed which is to be affixed to the supplemental form. **For Group Classes that LHDs wish to bill to Medicaid, a PEF must be completed and entered into the PSRS.**

## **SPECIAL “HANDS” BILLING FUNCTIONS FOR THE SUPPLEMENTAL SYSTEM**

*Special Medicaid Billing Functions for HANDS are as follows:*

**Retro-Active Medicaid Change Inquiry:**

**CMRI<space><30><LOC><space><LOC><space><Patient ID><XMIT>**

Program will list all documents for the patient. From this screen the user has the ability to change the Medicaid eligible flag. Just place the appropriate letter next to the document that needs to be changed and transmit. The results of your change will go to queue #9.

The letters to use for changing are: “N” = Medicaid No / “Y” or “X” = Medicaid Yes

**On-Demand HANDS Re-Billing HCFA Inquiry:**

**CMOD<space><30><space><HID/LOC/S><space><DOCUMENT #><XMIT>**

Program will enter supplemental document number and fill in the HANDS Re-billing HCFA screen.

Please note: No A/R is created through this process. The user will have to create the A/R (if there is a need for one to be created). This process creates an electronic rebilling or a CMS 1500 form only.

## APPENDICES

### MEDICAID PRESUMPTIVE ELIGIBILITY (Maternity Patients Only)

- Patients coming in for pregnancy tests are to be registered as usual.
- Income screening is to be performed since pregnancy testing is a Family Planning service.
- If pregnancy test is negative, PEF entry and checkout will be performed as usual.
- If pregnancy test is positive and patient meets criteria for presumptive eligibility, patient should return to registration desk for determination of presumptive eligibility.
- Instructions given by Medicaid in Presumptive Eligibility trainings should be followed.
- Command to look up your Medicaid Provider # is PSIL 30 HID/LOC/S.
- After presumptive eligibility is determined and document is received from Medicaid, the following steps should be taken:
- Participant and MEDICAL PROVIDER who performed the pregnancy test service must sign the presumptive eligibility document and a copy must be made for the patient's medical record.
- Patient will have a new registration completed using the presumptive eligibility.
- An "E" will be entered in the Medicaid field for presumptively eligible patients and a beginning date for eligibility entered on the registration screen in the E BEG DT field.
- The "P" code previously used for a patient who was potentially eligible for Medicaid will be deleted and the "A" code will apply to both applied and pending patients.
- REMEMBER: The positive pregnancy adds one additional member to the household size.
- For presumptive eligibility, the WIC income proof code will be the same as the code for a person who has a Medicaid card or who has KCHIP I or II.
- A new PEF label is to be run containing the newly determined eligibility information.
- The original PEF and the new PEF are stapled together. The original PEF number is voided at checkout.
- The new PEF is entered into the system under the new PEF number with the information contained on both the original and new PEF's.
- At the end of the eligibility period, CDP will automatically change the "E" to an "A".
- When the patient returns for **billable** services after the end of the presumptive eligibility period, determine their Medicaid status and enter the correct code into PSRS.
- If you forget to enter current Medicaid status, billable services will appear on the 375 Medicaid Applied/Pending report.
- A determination will be made as to whether the patient has Medicaid eligibility by the staff that works the 375 report each month using the MDID function.
- The NERI function is used to change the patient's Medicaid status for the previous visits listed on the 375 report.

- REMEMBER: If you do not change the “A” to either a “Y” or an “N”, these services will not be billed to any third parties or considered as an allowable service for MOA purposes.
- The WIC policies that are currently in place will apply to presumptive eligibility patients as they do to those patients having Medicaid or KCHIP I or II.

**LOCAL HEALTH DEPARTMENT**  
**PATIENT SELF-PAY FEE MATRIX**  
 Effective July 1, 2002

Cost Center	Default Patient Self-Pay Fees	Exceptions to Default Fees
800 Pediatrics/Adolescents	Sliding based on State Average Cost*	Nominal for Childhood Immunizations*
802 Family Planning	Sliding based on State Average Cost*	
803 Maternity	Sliding based on State Average Cost*	
805 Medical Nutrition	Sliding based on State Average Cost*	
806 Tuberculosis	Nominal of 50% of State Average Cost with \$5.00 max*	Fixed Full Charge for services not included in PHPR**
807 Sexually Transmitted Disease	Nominal of 50% of State Average Cost with \$5.00 max*	
809 Diabetes	Sliding based on State Average Cost*	Fixed Full Charge for services not included in PHPR**
810 Adult	Sliding based on State Average Cost*	Fixed Full Charge for Adult Immunizations** Nominal for Flu and Pneumonia*
811 Lead	Sliding based on State Average Cost*	Fixed Full Charge for other Problem Visits not included in PHPR**
813 Breast & Cervical Cancer	Sliding based on State Average Cost*	

\* System will automatically compute correct fee.

\*\* Must enter "F" in the Fixed Full Charge field on PEF Entry Screen for system to compute correct fee.

**UNIFORM PERCENTAGE PAYMENT SCHEDULE**  
 (By Number In Household and Household Annual Income Range)  
 Effective 04/01/09

**SLIDING FEE (501)**

DTD January 23, 2009  
 Fed. Register Vol.74 No.14

% Poverty Level Range	% Pay	1	2	3	4	5	6	7	8	9	10	11	12
<100%		0-	0-	0-	0-	0-	0-	0-	0-	0-	0-	0-	0-
100%	0%	\$10,830	\$14,570	\$18,310	\$22,050	\$25,790	\$29,530	\$33,270	\$37,010	\$40,750	\$44,490	\$48,230	\$51,970
>100%		\$10,831	\$14,571	\$18,311	\$22,051	\$25,791	\$29,531	\$33,271	\$37,011	\$40,751	\$44,491	\$48,231	\$51,971
117%	5%	\$12,671	\$17,047	\$21,423	\$25,799	\$30,174	\$34,550	\$38,926	\$43,302	\$47,678	\$52,053	\$56,429	\$60,805
>117%		\$12,672	\$17,048	\$21,424	\$25,800	\$30,175	\$34,551	\$38,927	\$43,303	\$47,679	\$52,054	\$56,430	\$60,806
133%	10%	\$14,404	\$19,378	\$24,352	\$29,327	\$34,301	\$39,275	\$44,249	\$49,223	\$54,198	\$59,172	\$64,146	\$69,120
>133%		\$14,405	\$19,379	\$24,353	\$29,328	\$34,302	\$39,276	\$44,250	\$49,224	\$54,199	\$59,173	\$64,147	\$69,121
150%	20%	\$16,245	\$21,855	\$27,465	\$33,075	\$38,685	\$44,295	\$49,905	\$55,515	\$61,125	\$66,735	\$72,345	\$77,955
>150%		\$16,246	\$21,856	\$27,466	\$33,076	\$38,686	\$44,296	\$49,906	\$55,516	\$61,126	\$66,736	\$72,346	\$77,956
167%	30%	\$18,086	\$24,332	\$30,578	\$36,824	\$43,069	\$49,315	\$55,561	\$61,807	\$68,053	\$74,298	\$80,544	\$86,790
>167%		\$18,087	\$24,333	\$30,579	\$36,825	\$43,070	\$49,316	\$55,562	\$61,808	\$68,054	\$74,299	\$80,545	\$86,791
183%	45%	\$19,819	\$26,663	\$33,507	\$40,352	\$47,196	\$54,040	\$60,884	\$67,728	\$74,573	\$81,417	\$88,261	\$95,105
>183%		\$19,820	\$26,664	\$33,508	\$40,353	\$47,197	\$54,041	\$60,885	\$67,729	\$74,574	\$81,418	\$88,262	\$95,106
200%	60%	\$21,660	\$29,140	\$36,620	\$44,100	\$51,580	\$59,060	\$66,540	\$74,020	\$81,500	\$88,980	\$96,460	\$103,940
<b>185%</b>		<b>\$20,036</b>	<b>\$26,955</b>	<b>\$33,874</b>	<b>\$40,793</b>	<b>\$47,712</b>	<b>\$54,631</b>	<b>\$61,550</b>	<b>\$68,469</b>	<b>\$75,388</b>	<b>\$82,307</b>	<b>\$89,226</b>	<b>\$96,145</b>
>200%		\$21,661	\$29,141	\$36,621	\$44,101	\$51,581	\$59,061	\$66,541	\$74,021	\$81,501	\$88,981	\$96,461	\$103,941
217%	75%	\$23,501	\$31,617	\$39,733	\$47,849	\$55,964	\$64,080	\$72,196	\$80,312	\$88,428	\$96,543	\$104,659	\$112,775
>217%		\$23,502	\$31,618	\$39,734	\$47,850	\$55,965	\$64,081	\$72,197	\$80,313	\$88,429	\$96,544	\$104,660	\$112,776
233%	90%	\$25,234	\$33,948	\$42,662	\$51,377	\$60,091	\$68,805	\$77,519	\$86,233	\$94,948	\$103,662	\$112,376	\$121,090
>233%		\$25,235	\$33,949	\$42,663	\$51,378	\$60,092	\$68,806	\$77,520	\$86,234	\$94,949	\$103,663	\$112,377	\$121,091
250%	95%	\$27,075	\$36,425	\$45,775	\$55,125	\$64,475	\$73,825	\$83,175	\$92,525	\$101,875	\$111,225	\$120,575	\$129,925
>250% & Above	100%	\$27,076 & Above	\$36,426 & Above	\$45,776 & Above	\$55,126 & Above	\$64,476 & Above	\$73,826 & Above	\$83,176 & Above	\$92,526 & Above	\$101,876 & Above	\$111,226 & Above	\$120,576 & Above	\$129,926 & Above

Payment Scale: 100%-250% Poverty Level as per DHHS Poverty Income Guidelines 01/23/2009

Revised 02/23/2009

## HOUSEHOLD SIZE AND HOUSEHOLD INCOME

1. Household size and household income is not required for any health department service if the applicant is receiving:
  - Medicaid, including Medicaid Presumptive Eligibility (MPE), Medicaid Breast and Cervical Cancer Treatment Program (MBCCTP), Kentucky Children's Health Insurance Program (KCHIP) Phase I, and KCHIP Phase II, or
  - Medicaid as a newborn infant whose mother was Medicaid eligible at the time of delivery, or
  - KCHIP Phase III, except when the service is WIC certification and household size and income is required. See "[WIC Income Eligibility Requirements.](#)" following these pages.

NOTE: The plastic Medicaid card (KYHealth Card) does not contain dates to determine eligibility. Medicaid eligibility must be verified through the KYHealth-Net system. The KYHealth-Net system shows Medicaid eligibility and the type of Medicaid coverage. If this system is not operational, verification of current eligibility may be obtained from the PSRS look-up (MDID), the Voice Response system (800 number), or the local Department for Community Based Services (DCBS) office.

### FOR BILLING PURPOSES:

A copy of the KYHealth-Net screen showing Medicaid eligibility must be made and filed in the individual's medical record. A copy of this screen should be made at the provision of the first billable service of the month. A copy of this screen is the only acceptable documentation of eligibility for re-submission of billings that have been denied due to patient not eligible at time of service. A copy of the MDID screen is not acceptable for billing re-submissions.

For Medical Presumptive Eligibility (MPE) and Medicaid Breast and Cervical Cancer Treatment Program (MBCCTP), a copy of the identification sheet for MPE or MBCCTP should be made and filed in the individual's medical record. This copy should be obtained at the provision of the first billable service of the month. A copy of the MDID screen is not acceptable for billing re-submissions.

2. Household size and current household income is required for:
  - a. Any service for which the Uniform Percentage Payment Schedule is applied. This schedule, along with the household income, determines the payment for the service. Payment percentage should be determined prior to the delivery of services.
  - b. WIC certification when adjunct eligibility or transfer of eligibility does not apply. See "[WIC Income Eligibility Requirements](#)" following these pages.
3. Household size and household income shall be determined in a confidential manner.
4. Household size and household income shall be determined at no cost to the applicant.

5. Proof of household income is not required for any services except WIC certification. See ["WIC Income Eligibility Requirements"](#) following these pages.
6. Household size and household income must be documented for each individual when applying the Uniform Percentage Payment Schedule or [WIC Income Eligibility Guidelines](#) and filed in that individual's medical record. Documentation is done by completing the Patient Registration Screen(s), printing registration/income labels and completing the Registration, Authorizations, Certifications, and Consents form (CH-5). If the automated system is unavailable, the Patient Registration and Income Determination form (CH-5B) must be completed and filed in the medical record, and data subsequently entered in the system.
7. Once determined and documented, household size and household income is valid for six (6) months except for WIC certification. If household size and household income has been established within the past six (6) months or within the current pregnancy for pregnant women, it is not required to collect household income again when the patient presents for additional services. If household income was determined more than six (6) months from the date that the patient presents for services, household size and household income must be determined. If the household size and household income remain the same as that collected six months ago, the patient may sign and date the current registration form for all services except WIC certification. See ["WIC Income Eligibility Requirements."](#)
8. Current household income or the household income during the past twelve (12) months may be considered to determine which more accurately reflects the status.
9. Income for persons who are unemployed shall be the income during the period of unemployment.
10. Persons who are on leave that they themselves requested (i.e., maternity leave or a teacher not being paid during the summer) are not considered unemployed. Therefore, the person's income earned during the regular employment period must be averaged to determine annual income.
11. The weekly, bimonthly or monthly income shall be converted to annual household income for application of the Uniform Percentage Payment Schedule and [WIC Income Eligibility Guidelines](#).

### **Determining Household Size**

1. Household is defined as a group of related or non-related individuals who are living together as one economic unit. Household members share economic resources and consumption of goods and/or services. The terms "economic unit" and "household" are used interchangeably. Residents of a facility, such as a homeless facility or an institution, shall not all be considered as members of a single household/economic unit.
2. It is reasonable that persons living in the residence of others, whether related or not, are likely to be receiving support and some commingling of resources. This would make them members of the economic unit with which they live. However, a household may consist of

more than one economic unit. Appropriate questioning must be done to make a reasonable determination of whether resources are shared or not. See guidance below:

3. To determine the size of the household, consider the guidance below:

- **Separate Economic Unit:** A person, or group of persons, living in the same house with other individuals may be a separate economic unit if he/she/they have their own source of income and the income is sufficient to cover living expenses (food, clothing, etc.).

*Questions to Ask:* Do you share income and expenses with other people? If yes, count all members as one household. Does the household provide you food, clothing, shelter, etc., with no expectation of payment or in-kind benefits? If yes, count all members as one household. Do you pay the household for living in their home or exchange household chores for living expenses? If yes, the applicant is a separate household.

- **Pregnant Woman:** A pregnant woman's household is increased by one for each unborn child. If she is expecting one child, count her as two; if she is expecting twins, count her as three; and so on. The increased household size should be used for other household members applying for services when determining their household size.

NOTE: If the applicant has a cultural or religious objection to counting the unborn child/children, this shall not be done. The objection should be documented in the patient medical record since it affects household size and income determination.

- **Unmarried Couple:** An unmarried couple living together as one household counts the income of both parties and counts both in the household size. Income for all persons supporting the household is counted.
- **Child:** A child is counted in the household size of the parent, guardian or caretaker with whom he/she lives.
- **Foster Child:** A foster child is a separate household of one as long as he/she is the legal responsibility of a welfare, social service, or other agency. Foster children less than 18 years of age are eligible for Medicaid. Department for Community Based Services applies for Medicaid on behalf of the child. The foster child's Medicaid eligibility cannot be used to establish WIC eligibility of other members of the household.

*Questions To Ask:* Is the child the legal responsibility of a welfare agency or social service agency? If yes, the applicant is a household of one.

- **Joint Custody:** In joint custody, or cases where the child may live with both parents equally, the child is counted in the household of the parent or guardian who is seeking services for the child. The child is not counted in the household size of the other parent/guardian.
- **Child Residing With Caretaker:** A child in the care of a friend or relative is considered a part of the household of the caretaker with whom he/she is residing. All persons with income supporting the household are considered, including any monetary support provided from the parent(s).

- **Adopted Child:** An adopted child or a child for whom a family has accepted the legal responsibility is counted in the household size with whom he/she resides.
- **Student:** A child residing in a school or institution who is being supported by the parent/caretaker, is counted in the household size of the parent/caretaker.
- **Alien/Foreign Individual:** It is legal for an alien/foreign individual and his/her family to apply for services. He/she/they are members of the household in which he/she/they reside.
- **Military:** Military personnel serving overseas or assigned to a military base, even though they are not living with their families, are counted as members of the household, along with the military personnel's gross income.  
**Military Family in Temporary Residence of Friends or Relatives:** When military personnel are deployed or assigned to a military base and temporarily absent from home, their family (children [if parents are deployed], children and one parent, or spouse) may temporarily move in with friends or relatives. In this situation, flexibility is allowed to ensure minimal impact on military family member's eligibility and/or receipt of services. The "military family" household size is determined through the following options:
  - a. Count the "military family" as it was prior to the deployment/assignment of the military person(s) as a separate economic unit. This option counts the deployed person(s) and gross income. Use of this option is dependent on whether the total gross income for this economic unit can be reasonably determined.
  - b. Count the "military family" as it is now as a separate economic unit without the deployed person(s). This option does not count the deployed person(s). To consider as a separate economic unit, the unit must have its own source of income, e.g., allotment to the spouse and/or children.
  - c. Count the "military family" as part of the household of the person(s) they reside with. All persons and all income for this household are counted.
- **Homeless:** Individuals whose primary residence is a shelter providing temporary living accommodations or who lack a fixed and regular nighttime residence are considered homeless and are considered a separate household.  
*Questions To Ask:* Do you lack a fixed and regular nighttime residence? If yes, count as a separate household. Is your primary nighttime residence a shelter for temporary living accommodations? If yes, count as a separate household.

4. Exceptions:

- **Maternity Services Exception ONLY:** A pregnant woman who conceives prior to her 21<sup>st</sup> birthday and resides with her parents/guardian, but whose parents/guardian will not be providing her with financial support for maternity care, shall be counted as a separate household. (If the pregnant woman is married or has dependent children living with her, her husband, her children and she are a separate household.)
- **Clarification for Minor Family Planning Patients:** Unless a minor is completely emancipated under state law, regulations as to ability to pay must be based upon the minor's household income. Only when a minor is unable to pay for services without having to inform his/her parents and the minor requests services on a confidential basis should the project look solely to the minor's income.

## **Household Income Definition**

1. Income earned or received by all members of the household includes:
  - a. Gross income (before deductions for taxes, social security, insurance, etc.) for the following:
    - Monetary compensation for services, including wages, salary, commissions, fees, and overtime.
    - Public assistance or welfare payments (KTAP, Supplemental Security Income [SSI], etc.).
    - Pensions or retirement.
    - Black lung or other disability payment.
    - Social Security benefits.
    - Government civilian employee or military retirement or pensions or veterans' payments/benefits.
    - Unemployment compensation or worker's compensation.
    - Alimony and child support payments.
    - Payment from the military including food and clothing allowance. Do not include housing allowance.
    - Other income such as:
      - Regular contributions from person not living in the household.
      - Dividends or interest on savings or bonds, income from estates, trusts, or investments.
      - College or university scholarships, grants, fellowships, and assistance except as excluded below.
      - Strike benefits.
      - Payments or winnings from gaming, gambling, lottery, and bingo.
      - Cash received or withdrawn from any source, including savings, investments, trusts.
      - Lump sum payments. These are defined as follows:
        - 1) Lump sum payments that represent new money intended for income is counted as income. Examples include: gifts, inheritance, lottery winnings, worker's compensation for lost wages, severance pay, and insurance payments for "pain and suffering." Lump sum payments for winnings and proceeds from gaming, gambling, and bingo are also counted as income.
        - 2) Lump sum payments that represent reimbursement for lost assets or injuries should *not* be counted as income. Examples include: amounts received from insurance companies for loss or damage of personal property, such as home or auto; payments that are intended for a third party to pay for a specific expense incurred by a household, such as a payment of medical bills resulting from an accident or injury.
        - 3) The lump sum payment may be counted as annual income or may be divided by 12 to estimate a monthly income, whichever is most applicable.

- b. Net income (determine net by subtracting operating expenses from the total amount made) only for the following:
- Net royalties.
  - Net rental income.
  - Net income from farm (money from tobacco, crops, etc.) or non-farm self-employment.
2. Income cannot be reduced for hardships, high medical bills, child care payments, taxes, child support, alimony, insurance, or other deductions.
3. The following shall NOT be considered as income:
- Non-cash benefits, in-kind housing, and in-kind benefits such as employer paid or union-paid portion of health insurance or other employee fringe benefits, food, or housing received in lieu of wages.
  - Capital gains, the sale of property, a house, or a car.
  - One-time payments from a welfare agency to a family or person who is in temporary financial difficulty.
  - Tax refunds.
  - Federal non-cash benefits programs: [Medicare](#), [Medicaid](#), [National School Lunch Act](#), [Child Nutrition Act of 1966](#), [Food Stamp Act of 1977](#).
  - Payments or allowances from the [Home Energy Assistance Act of 1981](#); Reimbursements from the Home Energy Assistance Act of 1981; payment to volunteers under Title I (VISTA and others), Title II (RSVP foster grandparents and others) of the [Domestic Volunteer Service Act](#); payment to volunteers of the [Small Business Act](#) (SCORE and ACE); payments received under the [Job Training Partnership Act](#) (JTPA).
  - Educational grants and tuition assistance received from any program funded in whole or in part under [Title IV of The Higher Education Act of 1965](#) (Pell Grants, State Student Incentive Grants, National Direct Student Loans, Supplemental Educational Opportunity Grant, State Student Incentive Grants, PLUS, College Work Study, And Byrd Honor Scholarship programs).
  - Cash or non-cash payments from a Child Care and Development Block Grant or other purchase of child care subsidy.
  - Earned Income Tax Credit (EITC) payment/refund.
  - Loans to which the applicant does not have constant or unlimited access.
  - Family Subsistence Supplemental Allowance (FSSA). This is a payment made to certain members of the Armed Forces and their families by the Department of Defense.
  - For military personnel:
    - Military Housing allowance (off-base and on-base housing allowances). Such housing allowances include Basic Allowance for Housing (BAH), Family Separation Housing (FSH) and Overseas Housing Allowance (OHA).
    - Overseas Continental United States cost of living allowance (OCONUS COLA) provided to military personnel in high cost of living areas outside the contiguous United States.

### **Computing Household Income**

1. Consider the current household income or the household income during the past 12 months to determine which indicator more accurately reflects the status. Current income should be most recent available, with monthly income the month prior to application.

Exceptions to this provision are:

- a. Unemployed person (including laid-off workers), use current household income.
  - b. Self-employed or seasonally employed person whose household income fluctuates through the year, use annual.
  - c. Person on temporary leave (maternity, family leave, extended vacation), use annual. (This is not considered unemployed.)
  - d. Teacher paid on ten (10) month basis, use annual.
  - e. Person on strike, use current household income including any strike benefits.
2. Sources of income for the household may not be the same time frame (weekly, monthly, etc.), so the income must be converted to common terms to determine total household income.
    - a. Calculate total income, use the table below:

<b>Frequency</b>	<b>To Obtain Monthly Income</b>	<b>To Obtain Annual Income</b>
Weekly	Multiply by 4.3	Multiply by 52
Different amount every week	Add the 4 checks, divide by 4 (weekly average) X 4.3	Add the 4 checks, divide by 4 (weekly average) X 52
Bi-weekly (every 2 weeks)	Multiply by 2.15	Multiply by 26
Semi-monthly (2x a month)	Multiply by 2	Multiply by 24
Monthly		Multiply by 12
Quarterly	Divide by 3	Multiply by 4
Annual	Divide by 12	
Hourly	Rate X hours per week X 4.3	Rate X hours per week X 52
Daily	Rate X 5 (or number of workdays per week) X 4.3	Rate X 5 (or number of workdays per week) X 52
Lump sums	Divide by 12	

- b. When all sources of income for the household have been converted to common terms, they are totaled and then rounded (e.g., less than 50 cents, round down) to the nearest dollar. This rounded total is compared to the income eligibility guidelines or the Uniform Percentage Payment Schedule.

### **Applicant Reporting Zero Household Income**

1. An applicant declaring zero income must be asked for information as to how basic living necessities such as food, shelter, medical care, and clothing are obtained. Persons living together and sharing resources are members of one economic unit.
2. When the interviewer is satisfied that the person's income is zero, the applicant's signature on the CH-5 is documentation. For WIC certification, see WIC Income Eligibility Requirements, Proof of Income for WIC Certification – ["Applicant Unable To Provide Proof of Income."](#)

### **Verification of Household Income**

Verification of income is not required. Income should be verified if the agency personnel have reasonable cause to believe the applicant's income is in excess of the income reported. If verification is requested, documentation of the reason for requesting verification shall be made in the person's medical record.

To verify the income of an individual/household, the following procedures shall apply:

1. Income verification shall be obtained in writing. The following are acceptable as verification:
  - a. Current pay stubs.
  - b. Statement from the employer or any responsible person who can verify income if the employer refuses to do so.
  - c. For self-employment income – ongoing records or tax returns.No person may be denied participation in services solely because the employer refuses to verify income.
2. Any difference in income shall be discussed with the patient and the patient shall be asked to explain. All documentation shall be entered into the medical record. For WIC, see [“WIC Income Eligibility Requirements.”](#) For other services, contact the appropriate program staff.

## WIC INCOME ELIGIBILITY REQUIREMENTS

1. Income eligibility must be determined and documented for all applicants at initial certification and at recertification. Exceptions are persons transferring with valid eligibility, with a VOC, or an instream migrant participant whose income must only be determined once in a twelve (12) month period. If the time frame of the migrant's income determination is not known, income eligibility must be done at certification.

NOTE: Migrants must be assessed for nutritional risk at every certification regardless of income eligibility.

2. An applicant can meet income eligibility requirements for the WIC Program in one of two ways:
  - Adjunct eligibility, which is automatic income eligibility for WIC based on documented eligibility for certain programs. See [“Adjunct Eligibility”](#) on the following pages. For an applicant who is not adjunct eligible, household income screening is required.
  - Income screening, which is determining the number in the household and total household income, and comparing to the income eligibility guidelines. See [“Household Size and Household Income.”](#)
3. Adjunct eligibility must be determined before income screening.
4. For an applicant who is not adjunct eligible, the number in the household and the total household income must be determined and compared to the income eligibility guidelines. Applicants whose household income is at or below 185% of the federal poverty income guidelines issued annually by the Department of Health and Human Services are eligible for WIC services. Income guidelines are effective from April 1 to March 30 each year. See [Income Eligibility Guidelines](#) on the following pages.
5. Proof of income for the household or proof/verification of adjunct eligibility must be provided for each WIC certification or recertification and the type of proof documented. Proof of income must not be a barrier to participation.
6. Income eligibility or ineligibility and the type of proof presented must be documented. A code system is established for type of proof as the documentation method. Documentation must be made by entering the appropriate code on the Patient Registration Screen, or Patient Registration Income Screen 2 if applicable, and the CH-5. If system access is not available, the CH-5B must be completed and must include the code for the type of proof.
7. Persons determined ineligible due to income must be provided written notice of the ineligibility, the reason for ineligibility, and the right to a fair hearing. See WIC PROGRAM section in AR Volume II, Ineligibility and Discontinuation of Benefits.
8. Income information should be provided by the applicant or parent/caretaker of the applicant. However, an authorized proxy may bring a child in for certification, but all

required information and proof must be presented. Refer to AR Volume II, WIC Section, Certification and Management, Use of Proxies.

9. Income eligibility must be determined before nutritional risk.
10. If household income has been documented, proof of income presented, and the type of proof documented for one member of the household within the last sixty (60) days and there is no change in household size or income, this information can be used for other household members being certified for WIC within that sixty-day period. All eligibility and documentation requirements for WIC must be met for the new applicant.

NOTE: Adjunct eligibility of a household member applies only as specified in Adjunct Eligibility below.

11. Income eligibility is applicable for the certification period. Local agencies are not required to reassess eligibility during a certification period and participants are not required to report income or household changes during the certification period. However, if new income or household information is obtained, WIC eligibility must be reassessed for all household members who have more than 90 days remaining in their certification period. When the time remaining in the certification period is 90 days or less, reassessment is not required since this is insufficient time to effect change. See [“New Income Information”](#) on the following pages.
12. Verification of the proof of income is not required. Verification is validation of proof presented, such as pay stubs or number in the household, through an external source other than the applicant. Such external sources include employer verification of salary, local welfare office verification, etc. Information should be verified if agency personnel have reasonable cause to believe that accurate information was not provided. If verification is requested, the reason shall be documented in the person’s medical record. Verification shall be obtained in writing. If the verification does not support WIC eligibility, WIC services shall be terminated for all household members affected. See [“New Income Information”](#) on the following pages and WIC Section, [“Ineligibility and Discontinuation of Benefits.”](#) A payback of benefits will be requested if it is determined to be cost efficient.

### **Adjunct Eligibility:**

1. Adjunct eligibility is automatic income eligibility for the WIC Program based on an individual’s documented current eligibility for specific programs or in certain situations, a household member’s documented eligibility. Qualifying based on a household member’s eligibility is identified as “WIC Household” (WH) eligibility.
  - a. An applicant eligible in one of the following on the date of the WIC certification is adjunct income eligible:
    - Medicaid, including Medicaid Presumptive Eligibility (MPE), Medicaid Breast and Cervical Cancer Treatment Program (MBCCTP), Kentucky Children’s Health Insurance Program (KCHIP) Phase I, and KCHIP Phase II, or
    - Food Stamps, or
    - Kentucky Transitional Assistance Program (KTAP).

- b. An applicant can qualify based on other household members' eligibility for specific programs. Documentation must be presented or verified for the household member and show the household member's eligibility on the date of the WIC certification. The following situations qualify as WIC Household (WH) eligibility:
- A newborn eligible under his/her mother's Medicaid eligibility (an infant born to a woman on Medicaid at delivery is automatically eligible for Medicaid), or
  - Member of a household which includes a pregnant woman that is currently eligible for Medicaid, including Medicaid Presumptive Eligibility and Medicaid Breast and Cervical Cancer Treatment Program, or
  - Member of a household which includes an infant that is currently eligible for Medicaid, or
  - Member of a household that includes anyone that is currently eligible for KTAP.
- c. The chart below summarizes who may qualify for adjunct income eligibility:

	<b>Medicaid</b>	<b>Food Stamps</b>	<b>KTAP</b>
<b>Pregnant Woman</b>	Self and household members	Self if name is on letter	Self and household members
<b>BF/PP Woman</b>	Self	Self if name is on letter	Self and household members
<b>Infant</b>	Self and household members	Self if name is on letter	Self and household members
<b>Child</b>	Self	Self if name is on letter	Self and household members

2. Current eligibility means eligibility in one of the specified programs on the date the WIC certification is done.
3. When adjunct eligible, the applicant is not screened for income eligibility and household income is not gathered.
4. For persons presenting as Medicaid eligible, current Medicaid eligibility must be verified and the type of coverage must be determined. The KYHealth card does not contain dates to determine current eligibility. For WIC adjunct eligibility, verification must be obtained through the KYHealth-Net system, the PSRS look-up (MDID), the Voice Response system (800 number), or the local Department for Community Based Services (DCBS) office.
5. Persons eligible for KCHIP Phase III are not adjunct income eligible. These persons must be screened for household size and household income. It must be determined if the individual is eligible for KCHIP III.
6. Individuals in the Passport Health Plan are not automatically income eligible for WIC. Passport includes Medicaid and KCHIP Phase III. To be adjunct eligible, it must be determined if the individual is eligible for Medicaid, not KCHIP Phase III. Persons with KCHIP III must be screened for household size and household income.

7. Persons who are adjunct eligible for WIC must be status eligible and meet the residency and nutritional risk criteria to qualify for WIC. Refer to the WIC Section, Certification and Management, WIC Eligibility Requirements.
8. Proof of eligibility in the above programs is required at each WIC certification and recertification for adjunct income eligibility. If a WIC household member's eligibility is being used for the applicant, proof/verification of current eligibility for the household member must be seen or obtained.
9. Persons that qualify based on "WH" eligibility, Medicaid Presumptive Eligibility, or Medicaid Breast and Cervical Cancer Treatment Program must present proof of residency and identification.
10. Examples of acceptable proof for adjunct eligibility are below. Proof must show eligibility on the date of the certification. For acceptable proof for specific situations, refer to WIC Adjunct Income Eligibility Proof Requirements and Documentation on the following pages.
  - Verification of current Medicaid eligibility\* for the applicant.
  - Verification of current Medicaid eligibility\* for the pregnant woman or infant that the applicant lives with.
  - Verification of Medicaid eligibility\* for the newborn's mother at the time of delivery.
    - \* For WIC adjunct eligibility, verification of current Medicaid eligibility must be obtained through the KYHealth-Net system, the Voice Response system, the PSRS look-up (MDID), or the local DCBS office.
  - Identification Sheet for Medicaid Presumptive Eligibility or Medicaid Breast and Cervical Cancer Treatment Program or MDID verification.
  - Verification of current Medicaid Presumptive Eligibility by the health care provider that determined it.
  - Letter confirming KTAP eligibility or a KTAP check stub for the applicant or a household member.
  - Food Stamps General Notice of Action letter with the applicant's name as an active member.
    - NOTE: Food Stamps EBT card cannot be used as proof of eligibility.
  - Verification of current MBCCTP eligibility by the health department staff that determined it.
11. The type of proof must be documented in the applicant's medical record. Documentation is done by completing the applicable field on the Patient Registration Screen with the appropriate proof code and placing the printed registration label on the CH-5 in the medical record. If printing problems prevent the codes from appearing on the label, the codes must be handwritten on the label and include staff initials and date. If eligibility is based on a household member, proof for this member must be seen, a "Y" entered in the WH field and proof code 23 entered in the appropriate field. If system access is unavailable, the CH-5B must be completed and include the appropriate codes. Refer to ["Instructions For Completing WIC Proof Fields"](#) on the following pages.

12. Applicant Failing To Bring Proof For Adjunct Eligibility at WIC Certification

Verification of current eligibility through KYHealth-Net, Voice Response, MDID, the DCBS Office, or the provider determining Medicaid Presumptive Eligibility is acceptable as proof. Verification by the health department staff that determined MBCCTP eligibility is acceptable proof.

If eligibility cannot be verified through the above procedures for the applicant who has proof but fails to bring it to the WIC certification/recertification, inform the applicant of the requirement for proof and make a new certification appointment within the timeframe for appointment scheduling. If the person has proof of household income with him/her, assess income for eligibility at this visit. Refer to WIC Section, Certification and Management, WIC Processing Standards and Scheduling.

13. Hospital Certification

If WIC certification is done in the hospital, refer to the WIC Section in AR Volume II, "Hospital Certification Requirements."

**Proof of Income for WIC Certification:**

1. Written proof of income for the household must be presented at each certification and recertification (except for transfer/VOC). See WIC ["Exceptions to Income Screening"](#) on the following pages.
2. Examples of acceptable proof of income are:
  - Current pay stub with amount and the pay timeframe (weekly, bi-weekly, monthly, etc.)
  - Signed statement from employer indicating gross earnings for a specified pay period.
  - W-2 forms or income tax return for most recent calendar year. Additional documentation or written statements of income may be requested to update this to current income.
  - Unemployment letter/notice.
  - Check stub/award letter from Social Security stating current amount of earnings.
  - Recent Leave and Earnings Statement (LES) for military personnel.
  - Foster child placement letter/foster parent award letter.
  - Tax forms or accounting records for self-employed.
  - Court decree or copies of checks for alimony or child support.
  - Letter from person(s) contributing resources.

**NOTE CONCERNING PAYCHECK STUBS:** If the pay is standard (does not vary), one paycheck for the most recent pay period prior to the application for WIC will be sufficient. However, if the pay varies (shift work, overtime, commissions, etc.), paycheck stubs during the month prior to application should be averaged to represent the amount received.

3. The type of proof(s) (e.g. pay stub, etc.) presented must be documented in the person's record. This documentation is done by completing the applicable proof field(s) on Screen 2 with the appropriate code and placing the printed label on the CH-5 in the chart. See Registration Screen 2 and the following pages for codes. Any type of proof without a code is reported as Code 50 "other." When this code is used, the actual type of proof must be documented in the person's medical record. If printing problems prevent the codes from appearing on the label, the codes must be handwritten on the label and include staff initials and date. If system access is unavailable, the CH-5B must be completed with appropriate proof codes.
4. **Applicant Failing to Bring Proof of Income at WIC Certification**  
For an applicant who has proof of income but fails to bring it to WIC certification, inform of the requirement for proof of household income and make a new certification appointment within the timeframe for appointment scheduling. Refer to the AR Volume I, Section VIII: LHD Operations for "Appointment and Scheduling Requirements for Personal Health Services" and WIC Section, Certification and Management, WIC Processing Standards and Scheduling.
5. **Applicant Unable to Provide Proof of Income**
  - a. An applicant who has no written proof of income, such as a migrant, a homeless person, or a person who works for cash, or who reports income as zero, can self-declare income and must provide a signed statement. An applicant where military service personnel are temporarily absent from home and proof of gross military income cannot be produced, may self-declare income and must provide a signed statement.
  - b. The statement must include why written proof of income cannot be provided, (i.e., homeless, migrant), the date, and the person's signature. For zero income, an explanation of how living expenses are met must be included.
  - c. The statement must be filed in the patient's record.
  - d. The statement is applicable only to the certification period for which it was provided. At recertification, if the person still has no proof of income, another statement must be obtained for this certification period.
  - e. The code for statement of no proof must be entered on Registration Screen 2. See the following pages for codes.

NOTE: An optional form, Statement of No Proof, is available for this purpose. See WIC Section in AR Volume II, "Forms and Supporting Information."
6. **Hospital Certification**  
If WIC certification is done in the hospital(s), see the WIC Section in AR Volume II, "Hospital Certification Requirements."

## **WIC Exceptions to Income Screening:**

1. Transfer Participant/VOC-A transfer is not screened for income eligibility nor required to show proof of income until the certification period expires and he/she is again screened for eligibility.
2. Migrant – Income eligibility should be determined for a migrant once every twelve (12) months. A VOC will provide income eligibility for up to one (1) year for a migrant. If the time frame of the migrant’s income determination is not known, income eligibility must be done at certification.
3. Hospital Certification – Mothers and newborn infants certified at the hospital are not required to show proof of income at the time of certification. Accept self-reported income and if eligible, certify and issue food instruments for thirty (30) days. Proof of adjunct eligibility or household income must be provided within thirty (30) days. See WIC Section in AR VOLUME II, “Hospital Certification Requirements.”
4. Adjunctively Eligible – These persons are excluded from providing proof of income but must show proof of adjunct eligibility. See [“Adjunct Eligibility.”](#)

## **New Income Information**

1. A participant’s income eligibility must be reassessed during a current certification period if information is received that indicates that the participant’s household income has changed if there is more than 90 days remaining in the certification period from the date information is received. Reassessment is not required for a participant when 90 days or less remains in the certification period.
2. Reassessment may result when:
  - Local agency staff has reason to believe that income information or household size provided at the certification was not accurate or complete.
  - A household member is assessed for income and is over the guidelines.
  - Income is required for other health services.
  - A participant/caretaker reports a change in income or Medicaid status.
3. When more than 90 days remains in a current certification period, reassessment is required. Procedures for reassessment are:
  - a. If the participant is no longer or not currently adjunct eligible (either based upon his status or a household member’s status), eligibility must be assessed for household size and household income to remain on WIC. All income guidelines apply concerning current and annual income. See previous pages.
  - b. If income exceeds WIC eligibility criteria, the participant shall be terminated from WIC if more than 90 days remains in the certification period. Any other members of the household enrolled in WIC affected by new income information shall be terminated as well if the time remaining in their certification period is more than

90 days. For example, a pregnant woman applying for WIC does not meet the income criteria; her child enrolled in WIC has 4 months remaining in the certification period and must be reassessed for income eligibility. If adjunct eligibility does not apply, the child must be terminated.

- c. Termination must be appropriately documented in the medical record and include the reason for termination. See WIC PROGRAM section in AR VOLUME II, “Ineligibility and Discontinuation of Benefits” for appropriate documentation and termination procedures.

Income Guidelines for the WIC Program  
 185% of Poverty  
 Effective April 1, 2009 through March 31, 2010

	Household Size								For each additional household member add:
	1	2	3	4	5	6	7	8	
Weekly	\$386	\$519	\$652	\$785	\$918	\$1,051	\$1,184	\$1,317	+\$134
Bi-Weekly	\$771	\$1,037	\$1,303	\$1,569	\$1,836	\$2,102	\$2,368	\$2,634	+\$267
Twice-Monthly	\$835	\$1,124	\$1,412	\$1,700	\$1,988	\$2,277	\$2,565	\$2,853	+\$289
Monthly	\$1,670	\$2,247	\$2,823	\$3,400	\$3,976	\$4,553	\$5,130	\$5,706	+\$577
Annual	\$20,036	\$26,955	\$33,874	\$40,793	\$47,712	\$54,631	\$61,550	\$68,469	+\$6,919
Persons who receive Medicaid or Food Stamp benefits automatically meet the income requirements for the WIC Program.									

**INSTRUCTIONS FOR COMPLETING WIC PROOF FIELDS  
PATIENT REGISTRATION SCREEN (Screen 1)**

Proof:            Res [    ]        ID [    ]        Mdcd [    ]    KTAP [    ]    FDST [    ]  
                  (Residence)    (Identity)        (Medicaid)    (KTAP)        (Food Stamps)

Proof fields must be completed at each WIC certification and recertification. For VOC/transfers, residence and identity fields must be completed. For more information on residence and identity, refer to the WIC Section, Certification and Management, WIC Eligibility Requirements.

For residence and identity fields, enter the code from below for the type of proof presented for residence and identity. Appropriate codes are those indicated by “Yes” in the residence and/or identity columns. If the type of proof presented is not assigned a code in the list below, enter code 50 for “other” and document the specific type of proof in the person’s medical record.

For adjunct eligibility, if the person is adjunct eligible based on his/her eligibility for Medicaid or Food Stamps, enter the code for that program in the proof field. If the person provides proof of KTAP eligibility, use code 50 (other) and document the type of proof in the medical record. If the person qualifies based on the eligibility of a household member (WIC Household, “WH”), enter proof code 23 for “Adjunct Eligibility based on Household Member” in the applicable proof field. For example, if a child qualifies based upon an infant in the household receiving Medicaid, enter code 23 in the Medicaid proof field. For information on specific situations, refer to the following pages.

**INSTRUCTIONS FOR COMPLETING WIC PROOF FIELDS  
PATIENT REGISTRATION SCREEN (Screen 2)**

Screen 2 must be completed at each WIC certification and recertification if adjunct eligibility does not apply.

**Salaried Income: Proof (    ) :**

Must complete proof field for WIC certification and recertification. Enter the code from below for the type of proof presented for each income indicated. Appropriate codes for Screen 2 are 14-50 from the list below. If the type of proof presented is not assigned a code in the list below, enter code 50 for “other” and document in the medical record the type of proof presented.

**Other Income: Proof:**

Must complete proof field for WIC certification and recertification. Enter the code from below for the type of proof presented for each income indicated. If the type of proof presented is not assigned a code, enter code 50 for “other” and document in the medical record the type of proof presented.

The proof codes will be printed on the Registration/Income Label(s) and must be placed on the CH-5 for the medical record documentation. Registration labels with the applicable proof codes must be printed and placed on the CH-5 for each WIC certification and recertification. If printing problems prevent the codes from appearing on the label(s), the codes must be handwritten on the label and include staff initials and date. If the system is down or unavailable, the type of proof presented must be documented on the CH-5B to be entered in the system later.

# WIC PROOF OF RESIDENCE, IDENTITY AND INCOME

WIC Proof of Residence, Identity, and Income				
Screen Code	Type of Proof	Residence	Identity	Income
1	Current Medicaid <sup>1</sup> eligibility (KY Health-Net, MDID, Voice Response, DCBS) / Presumptive Eligibility ID / Medicaid BCCTP ID	Yes <sup>4</sup>	Yes <sup>4</sup>	Yes (See other side)
2	Food Stamp Letter DCBS Verification	Yes	Yes	Yes
3	Drivers License	Yes	Yes for adult	
4	Immunization Record		Yes	
5	Birth Certificate		Yes	
6	School ID or Record	Yes	Yes	
7	Hospital Record/Birth Card	Yes with address	Yes	
8	Voter Registration Card	Yes	Yes	
9	Current Mail/Bill	Yes	Yes	
10	Photo ID	Yes with address	Yes	
11	Social Security Card		Yes	
12	Property Tax Bill/Receipt	Yes	Yes with name	
13	Current Rent/Mortgage Lease/Receipt	Yes	Yes with name	
14	Statement of No Proof <sup>2</sup>	Yes	Yes	Yes
15	Staff Recognition <sup>3</sup>	Yes for recert. and Fls <sup>3</sup>	Yes for recert. and Fls <sup>3</sup>	
16	Current Pay Check/Stub	Yes with address	Yes with name	Yes if gross income
17	Tax Return/W-2 Form	Yes with address	Yes with name	Yes
18	Unemployment Letter	Yes with address	Yes with name	Yes
19	Social Security Earnings	Yes with address	Yes with name	Yes
20	Leave and Earnings (Military)	Yes with address	Yes with name	Yes
21	Participant Folder <sup>3</sup>		Yes for recert. and Fls <sup>3</sup>	
22	Medical Record <sup>3</sup>		Yes for recert. and Fls <sup>3</sup>	
23	Adjunct Eligibility based on Household Member	Yes with pt. address		Yes (See other side)
24	Hospital Certification	Proof required in 30 days	Proof required in 30 days	Proof required in 30 days
50	Other – Must document type of proof in patient chart	Yes with address	Yes with name	Yes if amount and time frame specified

- 1 Persons eligible for KTAP receive Medicaid. Any other proof for KTAP, use "other" code.
- 2 Statement is good for the certification period.
- 3 Acceptable proof must have been presented and documented before use.
- 4 Proof of residence and identity must be seen for Presumptive Eligibility and BCCTP.

WIC-PC 6/2009

# WIC ADJUNCT INCOME ELIGIBILITY PROOF REQUIREMENTS AND DOCUMENTATION

## WIC Adjunct Income Eligibility Proof Requirements and Documentation

Situation	Proof Required	Qualifies (Income only)	Screen Field/Code	Proof Field/Code
Pregnant (PG) Woman Receives Medicaid (including MPE, MBCCTP)	<ul style="list-style-type: none"> <li>• Verification of current Medicaid eligibility*</li> <li>• MBCCTP or MPE Identification Sheet</li> <li>• Verification by MPE Provider</li> </ul>	Pregnant Woman	Medicaid-Y Medicaid-E for MPE	Mdcd-01**
		Household Members	Medicaid-N WH-Y	Mdcd-23***
Breastfeeding/Postpartum (BF/PP) Woman Receives Medicaid (including MPE, MBCCTP)	<ul style="list-style-type: none"> <li>• Verification of current Medicaid eligibility*</li> <li>• MBCCTP or MBE Identification Sheet</li> <li>• Verification by MPE Provider</li> </ul>	BF/PP Woman	Medicaid-Y Medicaid-E for MPE	Mdcd-01**
Infant Receives Medicaid	<ul style="list-style-type: none"> <li>• Verification of current Medicaid eligibility*</li> </ul>	Infant	Medicaid-Y	Mdcd-01**
		Household Members	Medicaid-N WH-Y	Mdcd-23***
Newborn Infant's Mother Received Medicaid at Delivery	<ul style="list-style-type: none"> <li>• Verification of mom's Medicaid eligibility*</li> </ul>	Infant	Medicaid-M WH-Y	Mdcd-23***
Child Receives Medicaid	<ul style="list-style-type: none"> <li>• Verification of current Medicaid eligibility*</li> </ul>	Child Only	Medicaid-Y	Mdcd-01
Infant/Child Receives KCHIP Phase III	<ul style="list-style-type: none"> <li>• Not Adjunct Eligible</li> </ul>	No one	Medicaid-K	Not Adjunct Eligible
PG/BF/PP Woman/ Infant/Child Receives Food Stamps	<ul style="list-style-type: none"> <li>• General Notice of Action Letter with Applicant Name</li> <li>• DCBS Verification</li> </ul>	Person Listed on Letter	Food Stamps-Y	Fdst-02
PG/BF/PP Woman/ Infant/Child Receives KTAP	<ul style="list-style-type: none"> <li>• KTAP Letter</li> <li>• KTAP Check Stub</li> <li>• DCBS Verification</li> </ul>	Woman Infant/Child	KTAP-Y	KTAP-50
		Household Members	KTAP-N WH-Y	KTAP-23***

\* Verification through KYHealth-Net, Voice Response, or local DCBS is acceptable.

\*\* Women adjunct eligible based on MPE or MBCCTP must show proof of residence and identity.

\*\*\* Persons adjunct eligible based on another person's eligibility must show proof of residence and identity.

MPE = Medicaid Presumptive Eligibility

MBCCTP = Medicaid Breast and Cervical Cancer Treatment program

## PATIENT SERVICES REPORTING SYSTEM BILLING CODES

<u>CODE</u>	<u>DESCRIPTION</u>
1	<b><u>PATIENT</u></b> – There is a fee to be paid by the patient for the specific CPT/HPS/HDPC code and the patient does not have any governmental or private insurance coverage as the primary payor.
2	<b><u>MEDICAID</u></b> – There is a Medicaid Preventive Health Services/Managed Care/Primary Care fee for the specific CPT code and the patient has no other third party coverage as the primary payor.
3	<b><u>MEDICARE</u></b> – The CPT/HCPS codes(s) for an encounter are assigned this code if billable to Medicare as the primary payor.
4	<b><u>NON-ASSIGNED</u></b> – Used for applied/pending Medicaid Services. Also, used for services provided to employees as a condition of employment, flu vaccine for employees, and services to patients that had to be reported for reasons that were not caused by the patient.
7	<b><u>PROJECT ELIGIBLE</u></b> – There is not an applicable patient pay fee for the specific CPT code, the patient does not have either governmental, private insurance or other third party coverage and the cost of the service has not been included in any other CPT code that is billable to any payor.
8	<b><u>OTHER THIRD PARTY</u></b> – The CPT/HCPS code(s) for an encounter are assigned this code if billable to another Third Party as the primary payor.
9	<b><u>INSURANCE</u></b> – The CPT/HCPS code(s) for an encounter are assigned this code if billable to insurance as the primary payor.
15	<b><u>PATIENT PAID COINSURANCE/DEDUCTIBLE</u></b> – Used in the Billing – A/R system to identify coinsurance related to insurance payors.
16	<b><u>KENTUCKY EARLY INTERVENTION SYSTEM (KEIS)</u></b> – The CBIS Service codes for an encounter are assigned this code if covered by a provider agreement in the KEIS.

## EMPLOYEE CLASS ID, DESCRIPTION AND PROVIDER CLASS

<u>Employee/Provider Class No.</u>	<u>Description</u>	<u>Provider Class</u>
A1	General Practitioners & Family Practitioners	10
A2	Obstetricians/Gynecologists (board certified)	10
A3	Pediatricians	10
A4	Other Physician Specialists	10
B1	Dentists	10
B2	Dental Hygienists	50
C1	Nurse Practitioners/Midwives/Physician Assistants	20
C2	Public Health Nurses	30
C3	Other Registered Nurses	30
C4	LPNs or LVNs	35
C6	Other Registered Nurse	30
D1	Nutritionists	40
D2	Social Workers	40
D3	Health Educators/Epidemiologists	40
D4	Occupational Therapists	40
D5	Pharmacists	40
D6	Audiologists	40
D7	Speech Therapists	40
D8	Physical Therapists	40
D9	DHS Registered Dietitians	40
E1	Laboratory Technicians/Medical Assistant/RNA-LPNA	50
E2	X-Ray Technicians	50
E5	Physical Therapist Assistant	50
E6	Speech Therapist Assistant	50
E7	Occupational Therapist Assistant	50
E9	Child Development Specialist	50
G1	Environmentalists	90
G3	Environmental Supervisors	90
H1	Records Administrators	90
H2	Office Coordinator/Medical Support-Administration	90
H3	Medical and Social Support – Administration	90
H4	Office Coordinator/Medical Support-Direct Service	90
H5	Planners and Analysts	90
H6	Accountants	90
H7	Maintenance/Janitors	90
H8	Administrative Assistants/Program Specialists	90
H9	Administrators	90
J1	Health Officer/Physicians	10
J2	Medical Director	10
J3	District Director	90

## PERSONAL SERVICES CONTRACT AND PART-TIME EMPLOYEES

<u>Employee Provider Class No.</u>	<u>Description</u>	<u>Provider Class</u>
K1	General Practitioners and Family Practitioners	10
K2	Obstetricians/Gynecologists (board certified)	10
K3	Pediatricians	10
K4	Other Physician Specialists	10
L1	Dentists	10
L2	Dental Hygienists	50
M1	Nurse Practitioners/Nurse Midwives/ Physician Assistants	20
M2	Public Health Nurses	30
M3	Other Registered Nurses	30
M4	LPNs and LVNs	35
N4	Occupational Therapists	40
N6	Audiologists	40
N7	Speech Therapists	40
N8	Physical Therapists	40
N9	Registered Dieticians	40
S1	Other	90

Nurse Practitioners – Nurses who are registered with the Kentucky Board of Nursing as nurse practitioners.

Public Health Nurses – All registered nurses with a B.S. degree in nursing who are not nurse practitioners.

Other Registered Nurses – Any registered nurse other than nurse practitioners and public health nurses.

## **CPT PROVIDER CLASSIFICATION**

<b><u>CPT CLASS</u></b>	<b><u>PROVIDER CLASSIFICATION</u></b>
10	Physicians
20	Nurse Practitioners, Nurse Midwives, Physician Assistants
30	Registered Nurses
35	Licensed Practical Nurses
40	Allied Health Providers
50	Technicians/Assistants/RNA-LPNA
90	Others

# INDEPENDENT CONTRACT, 800 AND 600 NUMBER PROVIDER CONVERSION TABLE

## INDEPENDENT CONTRACT PROVIDERS

Minor Object Code	
200 & 201	Physicians (not certified Obstetrician/Gynecologists)
202	Board Certified Obstetrician/Gynecologists
204	Ophthalmologist/Optomtrist
205	Anesthesiologists/Other Physician Specialist
211	Dentists Services
215	Nurse Practitioners Services
217	Other Nurses Services
218	Social Worker/Health Educator
219	Nutritionists
220	Physical Therapist Services
221	Speech Therapist Services
222	Occupational Therapist Services
225	Other Therapist Services
227	Audiologist Services
229	Laboratory Technician/Medical and Therapist
240	Physical Therapist Assistant
241	Speech Therapist Assistant
242	Occupational Therapist Assistant
245	X-Ray/Other Testing Services
250	Laboratory Services (Written contract not required.)
255	Environmental Services
260	Other Providers of Medical Services
265	Medical Support
358	Pharmacy Services

## **800 NUMBER HEALTH PROVIDERS NOT ELSEWHERE CLASSIFIED**

The assignment of 800 numbers must be assigned by the Division of Administration and Financial Management.

<b>800 PROVIDER NUMBERS</b>	<b>PERSONNEL</b>
801	Physicians (Not Certified OB/GYN
802	Obstetrician/Gynecologist (Board Certified)
811	Dentist
815	Nurse Practitioner
817	Other Nurses
818	Social Worker
819	Nutritionist
820	Physical Therapist
822	Occupational Therapist
825	Other Therapist
827	Audiologist
829	Laboratory Technician/Medical Assistant/RNA-LPNA
845	X-Ray Services and Other Providers of Testing Services
850	Laboratories
860	Other Providers of Medical Services
865	Medical Support

NOTE: For DPH use only: The letter "Y" is to be in the first position of the provider number assigned to state contracted WIC agencies (i.e., Park Duvall and C&Y).

**DEPARTMENT FOR PUBLIC HEALTH OR STATE  
UNIVERSITY HEALTH PROFESSIONALS PROVIDING  
STATEWIDE SERVICES**

<b>ID NUMBERS</b>	<b>PERSONNEL</b>
60103	James S. Davis, MD
60401	U.K. Regional Pediatric Group (MD)
61002	U.K. Genetics
61003	U.L. Genetics
61503	Grace Florence, ARNP U.K. Regional Pediatric Group
61706	Jan Hatfield, RN
61707	Margaret Stevens, RN
61713	Rebecca McCoy, RN
64501	U.L. Brown Cancer Center (Mobile Mamm. Unit)
64502	Jewish Hospital, Cinn., OH (Mobile Mamm. Unit)
65000	State Lab
65001	Jefferson County Lead Lab
65002	CDC Atlanta, GA Lab

# **LOCAL HEALTH DEPARTMENT COST CENTERS**

Please refer to the Administrative Reference, Volume I, Section VI: Financial Management.

## COST CENTER ASSIGNMENTS BY ICD-9-CM CODES

**PRIMARY ICD-9-CM CODES:**

**COST CENTER:**

V202-; V703-; V705-; V03; V04;  
V05; V06; and V723-, V726-

**800** Pediatric (<21 yrs. old)  
Preventive

All ICD's Not Preventive or Assigned to  
another Cost Center

**800** Pediatric (<21 yrs. old)  
Reason Specific (other than those listed  
under Preventive)

V241-

Breastfeeding

V726-

Specimen Collection

V761; V762-; 6221-; 610 thru 611;  
7950-; 7938-; V723-; 2330-; 2331-  
V7647

Cancer Screening (<21 yrs. old)

V25

**802** Family Planning  
Preventive (Check ups) and  
Reason Specific (Other than  
Preventive Check-ups)

V2501- Initial Prescription of Oral Contraceptives  
V2502- Initial Prescription of other contraceptives  
V2509- Family Planning Counseling  
V251- Insertion of IUD  
V252- Sterilization  
V2541- Annual Prescription of Oral Contraceptives  
V2542- Annual prescription of IUD  
V2543- Annual Norplant check  
V2549- Annual prescription of other contraceptives  
V255- Initial insertion of Norplant

V268-

Preconceptional Counseling

V692-

High Risk Sexual Behavior  
(secondary position only)

V724-

Pregnancy Test

2662-\*\*\*

Folic Acid Deficiency

V1369-\*\*\*

Personal History of Congenital  
Malformations

## COST CENTER ASSIGNMENTS BY ICD-9-CM CODES (continued)

**PRIMARY ICD-9-CM CODES:**

**COST CENTER:**

V22; V23; V240-; V242-;  
630 thru 676; V202-; (<7 days); V502-;  
V30 thru V39

**803** Maternity

2699- and V241-  
2699-  
V241-

**804** WIC  
WIC Service  
Breastfeeding

WIC Cost Center is being assigned by unique CPT/HDPT codes (W0200, etc.)

V653-

**805** Medical Nutritional Counseling

V241-

Breastfeeding  
(secondary position only)

V741-; 7955-; V011-; and 010 thru 018

**806** TB

V016; V08; V6544; V6545; V7388;  
V7398; V745; 042; 07810; 07811;  
07819; 07888; 07951; 07952; 07953;  
07988; 07998; accessible codes in  
090 thru 099 sections; 131 section;  
61610 and 79571

**807** STD

V7389-

Screening for other  
specific viral disease (HIV)

V017-

Exposure to HIV

Services with CPT Codes preceded  
by X

**808** KEIS

250 thru 259\*\*

**809** Diabetes

6488-\*\*

Gestational Diabetes

## COST CENTER ASSIGNMENTS BY ICD-9-CM CODES (continued)

### PRIMARY ICD-9-CM CODES:

### COST CENTER:

V700-;  
V726-; V03; V04; V05;  
and V06.

**810** Adult Health (>21 yrs. old)  
Preventive

V158-; 272-; 401 thru 405  
V811-, V812-

**810** Adult Health –  
Cardiovascular Disease

V241-

Breastfeeding

V726-

Specimen Collection

ICD's not elsewhere listed  
for >21 yr. old patients

Adult Health – Other

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V700-;  
V761; V762-; V7647; 174; 179; 180; 182;  
183; 184; 6221-; 610 & 611;  
7950-; 7938-; V723-; 2330-; 2331-

**813** Cancer (>21 yrs. old)

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V1582\* or 3051\*

Smoking Cessation or Smoker;  
Tobacco Use Disorder  
May be primary position for  
WIC only patients receiving  
“Make Yours A Fresh Start Family”  
counseling.

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\* **Must** code on **all** patients who are smokers or who receive smoking cessation counseling.

\*\* **Must** code in the secondary position if diabetes is not primary reason for visit and patient is a diagnosed or a gestational diabetic.

\*\*\* **Always** coded when W0506 (multivitamins), W0507 (folic acid, prescription strength) and W0508 (folic acid 0.4 mg.) are reported.

\*\*\* **Must** code when folic acid coding alone is done.

\*\*\* **May** code when W0509 (prenatal vitamins) is reported.

Revised 03/2007

# KENTUCKY COUNTY CODES

(and codes from other states.)

<u>COUNTY</u>	<u>COUNTY</u>	<u>COUNTY</u>
001 ADAIR	041 GRANT	081 MASON
002 ALLEN	042 GRAVES	082 MEADE
003 ANDERSON	043 GRAYSON	083 MENIFEE
004 BALLARD	044 GREEN	084 MERCER
005 BARREN	045 GREENUP	085 METCALFE
006 BATH	046 HANCOCK	086 MONROE
007 BELL	047 HARDIN	087 MONTGOMERY
008 BOONE	048 HARLAN	088 MORGAN
009 BOURBON	049 HARRISON	089 MUHLENBERG
010 BOYD	050 HART	090 NELSON
011 BOYLE	051 HENDERSON	091 NICHOLAS
012 BRACKEN	052 HENRY	092 OHIO
013 BREATHTITT	053 HICKMAN	093 OLDHAM
014 BRECKINRIDGE	054 HOPKINS	094 OWEN
015 BULLITT	055 JACKSON	095 OWSLEY
016 BUTLER	056 JEFFERSON	096 PENDLETON
017 CALDWELL	057 JESSAMINE	097 PERRY
018 CALLOWAY	058 JOHNSON	098 PIKE
019 CAMPBELL	059 KENTON	099 POWELL
020 CARLISLE	060 KNOTT	100 PULASKI
021 CARROLL	061 KNOX	101 ROBERTSON
022 CARTER	062 LARUE	102 ROCKCASTLE
023 CASEY	063 LAUREL	103 ROWAN
024 CHRISTIAN	064 LAWRENCE	104 RUSSELL
025 CLARK	065 LEE	105 SCOTT
026 CLAY	066 LESLIE	106 SHELBY
027 CLINTON	067 LETCHER	107 SIMPSON
028 CRITTENDEN	068 LEWIS	108 SPENCER
029 CUMBERLAND	069 LINCOLN	109 TAYLOR
030 DAVIESS	070 LIVINGSTON	110 TODD
031 EDMONSON	071 LOGAN	111 TRIGG
032 ELLIOTT	072 LYON	112 TRIMBLE
033 ESTILL	073 MCCRACKEN	113 UNION
034 FAYETTE	074 MCCREARY	114 WARREN
035 FLEMING	075 MCLEAN	115 WASHINGTON
036 FLOYD	076 MADISON	116 WAYNE
037 FRANKLIN	077 MAGOFFIN	117 WEBSTER
038 FULTON	078 MARION	118 WHITLEY
039 GALLATIN	079 MARSHALL	119 WOLFE
040 GARRARD	080 MARTIN	120 WOODFORD

## STATE CODES

411 ILLINOIS	433 OHIO	444 VIRGINIA
412 INDIANA	440 TENNESSEE	446 WEST VIRGINIA
423 MISSOURI		600 any other state