

## MAC Binder Section 10 – Provider Communications

### Table of Contents with Document Summary

Located online at <http://chfs.ky.gov/dms/mac.htm>

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#### **1 – Prov Ltr re DSH Poverty Guidelines\_dte070915:**

DSH Hospital (01) and Mental Hospital (02) provider information regarding the determination of member eligibility for DSH funding; as well as information related to the DSH program and DSH billing information. Enclosed was an updated application which includes federal poverty guidelines that went into effect on April 1, 2015.

#### **2 – Prov Ltr re ICD-10 Implementation\_dte081215:**

Information related to provider preparedness and the Department's approach for ICD-10 implementation.

#### **3 – Prov Ltr re New Member Status\_dte081215:**

Important provider information related to three new member statuses that are outside of Medicaid eligibility; which providers may begin to see when checking member eligibility in KyHealthNet.



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

July 9, 2015

TO: DSH (01) Hospital Provider Letter #A-257  
Mental (02) Hospital Provider Letter #A-102

RE: DSH Poverty Guidelines 2015

Dear Provider:

Thank you for participating as a provider in the Medical Assistance Program. The enclosed application for the Disproportionate Share Hospital (DSH-001) is to be used by DSH hospitals to screen for Medicaid and KCHIP eligibility and to determine eligibility for funding under the DSH program. This updated application includes the federal poverty guidelines that went into effect on April 01, 2015. Completed applications are to be retained by the hospitals with the patient records. Also discussed in this letter is information about individuals eligibility about the DSH Program and DSH Billing Information.

**Individual Eligibility for the DSH Program**

**First**, an individual is to be screened for Medicaid or KCHIP eligibility prior to making a determination of eligibility for DSH funding. If an individual meets the criteria to be referred for Medicaid or KCHIP, you **may not submit** their data for DSH funding.

All referrals for Medicaid or KCHIP can be made by:

- visiting Kynect's website at <https://kynect.ky.gov/> or by contacting them at 855-459-6328
- visiting the local Department for Community Based Services (DCBS) office in the individual's county of residence or by contacting them at 855-306-8959

**Second**, only after an individual has applied and been denied Medicaid or KCHIP eligibility, **you may make** a determination of eligibility for DSH funds. Use the enclosed application to determine eligibility for DSH funds without referring to Kynect or DCBS



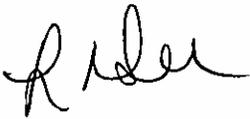
## DSH Billing Information

For **inpatient services**, the number of indigent inpatient days and the associated charges need to be submitted to the Department for Medicaid Services (DMS). For **outpatient services**, the number of visits and the associated charges for indigent care need be submitted to DMS. From this data, DMS will calculate your proportionate share of available DSH funds.

If you have additional questions regarding this communication, you may contact one of the numbers listed below:

- DSH eligibility, contact the Division of Policy and Operations at 502-564-6890
- DSH Billing, contact the Division of Fiscal Management at 502-564-8196
- Claims Submission, contact HP Provider Services at 1-800-807-1232

Sincerely,



Lisa D. Lee  
Commissioner  
Department for Medicaid Services

## Application for Disproportionate Share Hospital Program (DSH) and Medicaid/KCHIP Screening Form

*The following information is used to determine if an individual who requests or has already received hospital services is eligible for Disproportionate Share Hospital services or should be referred instead to the Department for Community Based Services (DCBS) to apply for Medicaid or KCHIP. Refer all children aged 19 and under to the DCBS office in the county of the individual's residence for a KCHIP eligibility determination.*

### Section 1: Individual Information

- |                                   |  |
|-----------------------------------|--|
| 1. Today's Date: _____            | 9. Work Phone: _____   |
| 2. Patient's Name: _____          | 10. Dates Hospital Provided Service: _____   |
| 3. Street Address: _____          | 11. Married/Single: _____  |
| 4. City: _____                    | 12. Name of Spouse: _____  |
| State: _____ Zip Code: _____      | 13. Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No                                      |
| 5. *Social Security Number: _____ | <i>If YES, refer the patient to DCBS for Medicaid eligibility determination</i>  |
| 6. Date of Birth: _____           | 7. Patient's Sex: _____  |
| 8. Home Phone: _____              | 14. Is the patient a resident of Kentucky? <input type="checkbox"/> Yes <input type="checkbox"/> No                        |
|                                   | <i>("Resident" is defined as a person living in Kentucky and who is not receiving public assistance in another state.)</i> |

*\* Please note that a Social Security Number is not required, and does not need to be provided. This information is only used to determine if the patient is currently receiving Medicaid. This information will not be shared, and will not be used for any other purpose.*

***If the answer to question 14 is yes, go to question 15. If the answer to question 14 is no, advise the patient that he/she does not meet criteria for eligibility for DSH and complete Section V.***

15. List the name, relationship, and age of each person living in the household.

Household Member's Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Does the individual have dependent children living in the home?  Yes  No
- (a) If the answer to question 16 is YES, refer the individual to DCBS for Medicaid;
- (b) If the answer to question 16 is NO, refer the individual to DCBS for Medicaid ONLY IF the individual has NOT received a denial from Medicaid within 30 days; or,
- (c) If the individual, who has no children less than 18 years of age, claims to be disabled, refer the individual both to DCBS to apply for Medicaid and to the Social Security Administration to apply for SSI
- \* See Criteria for Medicaid and KCHIP Eligibility on Page 4.**

#### 17. Income information

- a. Patient/Responsible Party Employer: \_\_\_\_\_
- b. Spouse Employer: \_\_\_\_\_
- c. Work Phone: \_\_\_\_\_
- d. Total Gross Monthly Income: \_\_\_\_\_
- e. Other Income:
- i. Unemployment: \_\_\_\_\_
  - ii. Child Support: \_\_\_\_\_
  - iii. Social Security: \_\_\_\_\_
  - iv. Workers Comp: \_\_\_\_\_
  - v. Other: \_\_\_\_\_
- Total Family Unit Gross Monthly Income: \$ \_\_\_\_\_**

#### 18. Insurance Information:

- a. Health/Life Insurance: \_\_\_\_\_
- b. Phone Number: \_\_\_\_\_
- c. Policy Number: \_\_\_\_\_
- d. Group Number: \_\_\_\_\_
- e. Policy Holder: \_\_\_\_\_
- f. Relation to Patient: \_\_\_\_\_

**19. Countable Resources:**

	Bank Name	Balance Value
a. Checking:	_____	_____
b. Savings	_____	_____
c. Money Market	_____	_____
d. Mutual Fund	_____	_____
e. Stocks	_____	_____
f. Bonds	_____	_____
g. Other	_____	_____
* Total Health Bills Owed:	_____	_____
*Total Resources:	_____	_____

*\*Countable Resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility.*

20. Other Information: a. Was date of service related to an auto accident?  Yes  No  
 b. Have you applied for and been denied Medicaid or KCHIP Benefits?  Yes  No

**Section 2: Hospital Indigent Care Criteria**

1. An individual must meet all of the following conditions:
- a. The individual is a resident of Kentucky
  - b. The individual is **not eligible** for Medicaid or KCHIP
  - c. The individual is **not** covered by a 3<sup>rd</sup> party payor
  - d. The individual is **not** in the custody of a unit of government which is responsible for coverage of the acute care needs of the individual.
  - e. The individual meets the following income and resource criteria:

Household Size	Resource Limit	100% of the Poverty Level (Monthly Income Limit)*	(Annual Income Limit)*
1	\$2,000.00	\$980.83	\$11,770.00
2	\$4,000.00	\$1,327.50	\$15,930.00
3	\$4,050.00	\$1,674.17	\$20,090.00
4	\$4,100.00	\$2,020.83	\$24,250.00
5	\$4,150.00	\$2,367.50	\$28,410.00

**Add an additional \$4,020.00 for each person.** *\*Income limits are effective April 1, 2015.*

2. All income of a family unit is to be counted and a family unit includes:
  - a. The individual;
  - b. The Individual spouse who lives in the home;
  - c. A parent or parents, of a minor child, who lives in the home;
  - d. All minor children who live in the home.
3. Related and nonrelated household member(s) who do not fall into one of the groups listed above shall be considered a separate family unit.
4. Countable resources are limited to cash, checking and savings accounts, stocks, bonds, certificates of deposit, and money market accounts.
5. Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility.

**Section 3: Certifying Accuracy of Information**

I hereby agree to furnish the Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that the Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources, and that failure to supply requested information within sixty (60) working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status, or income.

I agree to allow the Hospital representative to determine eligibility and pursue state and federal assistance with Medicaid, KCHIP and DSH.

I certify that the information provided on this application is correct to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact the hospital to make a hearing request.

\_\_\_\_\_  
Individual or Responsible Party's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hospital Employee Signature

\_\_\_\_\_  
Date

Does the individual appear to qualify for Medicaid?  Yes  No  
**If yes, then refer the individual to the DCBS office in the county of the individual's residence. The individual should take a copy of this form with him/her to the DCBS office.**

**Section 4: Refusal to Apply for Medicaid**

The individual or his responsible party shall sign below if he refuses to apply for Medicaid.

I refuse to apply for Medicaid or KCHIP coverage. I understand that this refusal may result in me being billed for any services performed.

\_\_\_\_\_  
Individual or Responsible Party's Signature

\_\_\_\_\_  
Date

**Section 5: Indigent Care Denial**

The individual does not meet the criteria for indigent care for the following reason (please check what applies):

1.  The individual is not a resident of Kentucky
2.  The individual has been referred to apply for Medicaid or KCHIP but has refused to apply.
3.  The individual already receives or has been approved for Medicaid or KCHIP.
4.  The individual has been referred to apply for Medicaid or KCHIP but has not shown at the end of 30 days that the application was filed
5.  The individual has been referred to an applied for Medicaid or KCHIP within 30 days but has not shown at the end of 120 days that the application has been denied or the application is pending.
6.  The individual did not provide within 60 days information needed to verify income, resources or employment status.
7.  The individual is covered by the following third party payor: \_\_\_\_\_
8.  The individual is in the custody of the following unit of government which is responsible for the coverage of the acute care needs of the individual: \_\_\_\_\_
9.  The household income of \$ \_\_\_\_\_ is too high
10.  The household resources of \$ \_\_\_\_\_ are too high, even when reduced by unpaid medical bills.

\*The individual believes that he/she is eligible for indigent care for the following reason:

**Section 6: Hearing Request**

The individual may request a fair hearing within 90 days of this determination either by:

1. Signing and dating the hearing request below and returning a copy of this application to the hospital, or
2. Sending a letter to the hospital requesting a hearing.

Hearing requests must be post marked or hand-delivered within 90 days of the date below to:

Name or Department: \_\_\_\_\_

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

I request a hearing on this denial. I believe I am eligible for indigent care.

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

*The hospital shall conduct a fair hearing within 30 days of receiving the individual's hearing request.*

\_\_\_\_\_  
This determination was made by:

\_\_\_\_\_  
Hospital Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Please see Page 4 for information regarding application stipulations.**

### **Medicaid and KCHIP Eligibility**

If the patient or household appear to be eligible for Medicaid or KCHIP:

- check the potential category of eligibility as listed below in this question
- complete the rest of this application and give a copy to the patient
- explain to the patient the requirement to apply for Medicaid or KCHIP within 30 days and report back within 120 days on whether the application:
  - has been approved or
  - has been denied or
  - is still pending

Refer to DCBS to apply for KCHIP or Medicaid if the patient is (check one):

- a child under 19
- an adult with related children living in the home
- pregnant
- 65 years old or older
- permanently disabled or blind or claims to be.

**Do not** refer a patient to DCBS to apply for Medicaid or KCHIP if the individual:

- received a denial of Medicaid or KCHIP within 30 days
- is an adult under 65 without related children in the home (unless the adult may meet the permanent and total disability criteria for Medicaid)

If an individual claims to be permanently and totally disabled, refer the individual both to DCBS to apply for Medicaid and to the Social Security Administration to apply for SSI.

If a patient demonstrates that s/he has applied for Medicaid or SSI but the application is still pending after the end of 120 days, approve this application.

### **Application Stipulations**

Hand or mail a copy of this application to any individual denied coverage with a cover letter stating the reason for denial and that the individual has 90 days to appeal.

If the individual has been referred to apply for Medicaid or KCHIP, attempt to contact after 30 days to see whether the individual has applied.

If an individual has applied for Medicaid (including SSI) or KCHIP, attempt contact at 60, 90 and 120 days to see whether the application was approved or denied.

If information needed to verify income, resources or employment is missing, attempt contact at 15, 30 and 45 days to remind the patient. Assist persons with disabilities as needed.

If a Medicaid or SSI application has been made but is still pending after 120 days, you may approve this application.

## Solicitud para el Programa de Hospitales con Población Desproporcionada (DSH por sus siglas en inglés) Y Formulario de Preselección de Medicaid/KCHIP

*La siguiente información es utilizada para determinar si un individuo que solicita o que ya ha recibido servicios del hospital es elegible para servicios de DSH o si debería ser remitido al Departamento para Servicios Basados en la Comunidad (DCBS) para solicitar el programa de Medicaid o KCHIP. Todos los niños de 19 años de edad o menores serán referidos a la oficina de DCBS del condado en que viven para una determinación de elegibilidad para KCHIP.*

### Sección 1: Información del individuo

1. Fecha de hoy: \_\_\_\_\_ 9. Teléfono del trabajo: \_\_\_\_\_
2. Nombre del paciente: \_\_\_\_\_ 10. Fecha del servicio hospitalario: \_\_\_\_\_ - \_\_\_\_\_
3. Dirección: \_\_\_\_\_ 11. Casado(a)/Soltero(a): \_\_\_\_\_
4. Ciudad: \_\_\_\_\_ 12. Nombre del cónyuge: \_\_\_\_\_
- Estado: \_\_\_\_\_ Código postal: \_\_\_\_\_ 13. ¿La paciente está embarazada?  Sí  No
5. \*Número de Seguro Social: \_\_\_\_\_ *Si responde Sí, remitir a la paciente al DCBS para una determinación de elegibilidad para Medicaid.*
6. Fecha de nacimiento: \_\_\_\_\_ 7. Sexo del paciente: \_\_\_\_\_ 14. ¿Es el/la paciente un residente de Kentucky?  Sí  No  
*(Se define como "residente" a un individuo que vive en Kentucky y que no recibe asistencia pública en otro estado.)*
8. Teléfono de casa: \_\_\_\_\_

*\* Favor de notar que no se requiere un Número de Seguro Social, y usted no tiene que proporcionarlo. Esta información se utiliza solamente para determinar si el paciente está recibiendo beneficios de Medicaid. Esta información no será divulgada, y no será utilizada para ningún otro propósito.*

***Si la respuesta a la pregunta 14 es sí, vaya a la pregunta 15. Si la respuesta a la pregunta 14 es no, infórmele al paciente que él/ella no cumple con los criterios de elegibilidad para DSH y llene completamente la sección V.***

15. Escriba el nombre, relación y edad de cada individuo que vive en el hogar.

Nombre del miembro del hogar	Relación	Edad
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. ¿El individuo tiene niños dependientes viviendo en el hogar?  Sí  No
- (a) Si la respuesta a la pregunta 16 es **SÍ**, remitir al individuo al DCBS para Medicaid;
- (b) Si la respuesta a la pregunta 16 es **NO**, remitir al individuo al DCBS para Medicaid ÚNICAMENTE SI la persona **NO** ha recibido una denegación de Medicaid en los últimos 30 días; o,
- (c) Si el individuo, que no tiene niños menores de 18 años de edad, afirma ser discapacitado, entonces remitir a este individuo al DCBS para solicitar Medicaid y la Administración del Seguro Social para solicitar Seguridad de Ingreso Suplementario.
- \* Favor de ver la página 4 para obtener más información sobre la elegibilidad para Medicaid/KCHIP.*

#### 17. Información de Ingresos:

- a. Empleador del Paciente/Parte Responsable: \_\_\_\_\_
- b. Empleador del Cónyuge: \_\_\_\_\_
- c. Teléfono del Trabajo: \_\_\_\_\_
- d. Total del Ingreso Bruto Mensual: \_\_\_\_\_
- e. Otro ingreso:
- i. Desempleo: \_\_\_\_\_
- ii. Manutención Infantil: \_\_\_\_\_
- iii. Seguro Social: \_\_\_\_\_
- iv. Compensaciones de los Trabajadores: \_\_\_\_\_
- v. Otro: \_\_\_\_\_
- Total del ingreso bruto mensual de la unidad familiar: \$ \_\_\_\_\_**

#### 18. Información de Seguro:

- a. Seguro de Salud/Vida: \_\_\_\_\_
- b. Número de Teléfono: \_\_\_\_\_
- c. Número de Póliza: \_\_\_\_\_
- d. Número de Grupo: \_\_\_\_\_
- e. Portador de la Póliza: \_\_\_\_\_
- f. Relación con el Paciente: \_\_\_\_\_

**19. Recursos Contables:**

	Nombre del Banco	Balance/Valor
a. Cuentas de cheques:	_____	_____
b. Cuentas de ahorros:	_____	_____
c. Mercado de valores:	_____	_____
d. Fondo común de inversión:	_____	_____
e. Acciones:	_____	_____
f. Bonos:	_____	_____
g. Otros:	_____	_____
*Total de deudas por facturas de salud: \$	_____	_____
*Total de recursos: \$	_____	_____

\* Para determinar la elegibilidad, a los recursos contables se les restarán los gastos médicos de la unidad familiar que no han sido pagados

20. Otra información: a. ¿La fecha de servicio estuvo relacionada con un accidente automovilístico?  Sí  No  
 b. ¿Usted ha solicitado y se le han denegado los beneficios de Medicaid o KCHIP?  Sí  No

**Sección 2: Criterios del Hospital con respecto al Cuidado para Indigentes**

1. El individuo tiene que cumplir con todas y cada una de las siguientes condiciones:
- El individuo es un residente de Kentucky
  - El individuo **no es elegible** para Medicaid o KCHIP
  - El individuo **no** tiene cobertura de un pagador a terceros
  - El individuo **no** está bajo la custodia de una entidad del gobierno responsable de la cobertura de sus necesidades de atención médica urgente
  - El individuo cumple con los siguientes criterios de ingreso y recursos:

Número de personas en el Hogar	Límite de Recursos	100% del Nivel de Pobreza (Límite de Ingreso Mensual)* *	100% del Nivel de Pobreza (Límite de Ingreso Anual)*
1	\$2,000.00	\$980.83	\$11,770.00
2	\$4,000.00	\$1,327.50	\$15,930.00
3	\$4,050.00	\$1,674.17	\$20,090.00
4	\$4,100.00	\$2,020.83	\$24,250.00
5	\$4,150.00	\$2,367.50	\$28,410.00

Sumar \$3,960.00 por cada persona adicional. \*Los límites de ingresos serán vigentes a partir del 1º de abril de 2015.

- Todos los ingresos de una unidad familiar serán contados y una unidad familiar incluye:
  - El individuo;
  - El cónyuge del individuo que vive en el hogar;
  - Uno de los padres o ambos padres de un menor de edad, que vive en el hogar;
  - Todos los menores de edad que viven en el hogar.
- Otros miembros del hogar ya sean parientes o no, y que no pertenecen a ninguna de las categorías mencionadas anteriormente deberán ser considerados como una unidad familiar independiente.
- Los recursos contables son limitados a dinero en efectivo, cuentas de cheque y cuentas de ahorros, acciones, bonos, certificados de depósito y cuentas de mercado de valores.
- Para determinar la elegibilidad, a los recursos contables se les pueden restar los gastos médicos de la unidad familiar que no han sido pagados.

**Sección 3: Certificación de la Fidelidad de Información**

Por este medio acepto suministrarle al hospital toda la información necesaria que les permita determinar la necesidad que tengo de recibir asistencia financiera para los servicios de atención de salud recibidos. Estoy de acuerdo en que se le proporcione al hospital o que este pueda obtener todos los documentos necesarios para verificar mis ingresos actuales, mi situación laboral y recursos, y que el hecho de no entregar la información requerida dentro de un plazo de treinta (30) días hábiles es motivo de denegación de mi solicitud de ayuda. También estoy de acuerdo en notificar al Hospital inmediatamente de cualquier cambio de dirección, número de teléfono, situación laboral o ingreso.

Estoy de acuerdo en permitir que el representante del Hospital determine mi elegibilidad y que busque asistencia estatal y federal con Medicaid, KCHIP y DSH.

Certifico que la información proporcionada en esta solicitud es correcta según mi leal saber y entender. Entiendo que si doy información falsa o retengo información al aceptar asistencia, podría estar sujeto a juicio por fraude. Entiendo que tengo el derecho de solicitar una audiencia justa si estoy insatisfecho con cualquier acción tomada acerca de mi solicitud. Entiendo que tengo que comunicarme con el hospital para solicitar una audiencia.

\_\_\_\_\_  
Firma del Individuo o Parte Responsable

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Empleado del Hospital

\_\_\_\_\_  
Fecha

¿El individuo parece calificar para Medicaid?  Sí  No

**Si responde Sí, entonces remitir al individuo a la oficina del DCBS del condado de residencia del individuo. El individuo debe llevar consigo una copia de este formulario a la oficina del DCBS.**

#### Sección 4: Negativa a Solicitar Medicaid

El individuo o la parte responsable firmará abajo si se niega a solicitar el Medicaid.

Me niego a solicitar la cobertura de Medicaid o KCHIP. Entiendo que como resultado de esta negativa se me pueden enviar a mí las facturas de cualquier servicio efectuado.

Firma del Individuo o Parte Responsable \_\_\_\_\_

Fecha \_\_\_\_\_

#### Sección 5: Negación del Cuidado para Indigentes

El individuo no cumple con los criterios de cuidado para indigentes por las siguientes razones (por favor marque lo que sea pertinente):

1.  El individuo no es un residente de Kentucky.
2.  El individuo ha sido referido para solicitar Medicaid o KCHIP pero se ha negado a hacerlo.
3.  El individuo ya recibe o ha sido aprobado para Medicaid o KCHIP.
4.  El individuo ha sido referido para solicitar Medicaid o KCHIP pero al concluir el plazo de 30 días no mostró pruebas de haber presentado la solicitud.
5.  El individuo ha sido referido para solicitar Medicaid o KCHIP en un plazo de 30 días pero al concluir los 120 días no mostró pruebas de que la solicitud ha sido denegada o de que la solicitud esté pendiente.
6.  El individuo no proporcionó en un plazo de 60 días la información necesaria para verificar ingreso, recursos o situación laboral.
7.  El individuo está cubierto por el siguiente pagador a terceros: \_\_\_\_\_.
8.  El individuo está bajo la custodia de una entidad del gobierno responsable de la cobertura de sus necesidades de atención médica urgente: \_\_\_\_\_.
9.  El ingreso del hogar de \$ \_\_\_\_\_ es muy alto.
10.  Los recursos del hogar de \$ \_\_\_\_\_ son muy altos, aún después de restarle las facturas médicas sin pagar.

\*El individuo cree que él/ella es elegible para el cuidado para indigentes por las siguientes razones:

#### Sección 6: Solicitud de Audiencia

El individuo puede solicitar una audiencia justa en un plazo de 90 días a partir de esta determinación y lo puede hacer ya sea:

1. Firmando y fechando la solicitud de audiencia que aparece a continuación y enviando una copia de esta solicitud al hospital, o
2. Enviando una carta al hospital donde solicita una audiencia.

La solicitud de audiencia tiene que ser enviada con fecha de matasellos o entregada personalmente en un plazo de 90 días a partir de la fecha que se muestra abajo:

Nombre o Departamento: \_\_\_\_\_

Hospital: \_\_\_\_\_

Dirección: \_\_\_\_\_

Yo solicito una audiencia debido a esta denegación. Yo creo que soy elegible para el cuidado para indigentes.

Firma del Paciente: \_\_\_\_\_ Fecha: \_\_\_\_\_

*El hospital debe llevar a cabo una audiencia justa en un plazo de 30 días a partir de la fecha en que recibe la solicitud de audiencia del individuo.*

#### Sección 7: Archivos Hospitalarios

Esta determinación fue llevada a cabo por:

Firma del Empleado del Hospital \_\_\_\_\_

Fecha \_\_\_\_\_

Testigo \_\_\_\_\_

Fecha \_\_\_\_\_

***Favor de ver la página 4 para obtener más información sobre las estipulaciones de solicitudes.***

**CONSERVAR UNA COPIA DE ESTA SOLICITUD EN EL EXPEDIENTE DEL PACIENTE.**

**ESTA DETERMINACIÓN ES VÁLIDA POR UN PERIODO DE SEIS MESES A MENOS QUE LA SITUACIÓN ECONÓMICA DEL INDIVIDUO CAMBIE.**

## Elegibilidad para Medicaid y KCHIP

Si el paciente o el hogar parecen ser elegibles para Medicaid o KCHIP:

marcar las posibles categorías de elegibilidad enumeradas a continuación de esta pregunta  
completar el resto de esta solicitud y entregar una copia al paciente  
explicarle al paciente que necesita hacer una solicitud para Medicaid o KCHIP en un plazo de 30 días y que tiene 120 días para informarnos si la solicitud:

- ha sido aprobada o
- ha sido denegada o
- está pendiente aún

Referir al DCBS para solicitar KCHIP o Medicaid si el paciente (marque uno):

es un niño menor de 19 años  
es un adulto con niños que viven en el hogar  
está embarazada  
tiene 65 años de edad o mayor  
es un discapacitado permanentemente o es ciego o dice serlo.

**No** referir al paciente al DCBS para solicitar Medicaid o KCHIP si el individuo:

recibió una denegación de Medicaid o KCHIP en los últimos 30 días  
es un adulto menor de 65 años sin niños en el hogar (a menos que el adulto cumpla con los criterios de incapacidad permanente y absoluta de Medicaid)

Si un individuo afirma tener incapacidad permanente absoluta, referir al individuo tanto al DCBS para solicitar Medicaid como a la Administración del Seguro Social para solicitar SSI.

Si el paciente demuestra que ha solicitado Medicaid o SSI pero la solicitud aún está pendiente después de finalizar los 120 días, apruebe esta solicitud.

## Estipulaciones de la Solicitud

Entregar personalmente o por correo una copia de esta solicitud a cualquier individuo que se le haya denegado la cobertura, mediante una carta indicando el motivo por el cual fue denegada e informándole que tiene 90 días para apelar.

Si el individuo ha sido referido para solicitar Medicaid o KCHIP, intentar comunicarse con dicho individuo después de 30 días para ver si el individuo hizo la solicitud.

Si un individuo hizo la solicitud de Medicaid (incluyendo SSI) o KCHIP, intentar comunicarse a los 60, 90 y 120 días para ver si la solicitud fue aprobada o denegada.

Si está faltando la información necesaria para verificar los ingresos, recursos o empleo, intentar comunicarse a los 15, 30 y 45 días para recordarle al paciente. Ayudar a las personas con discapacidades según sea necesario.

Si se ha hecho una solicitud para Medicaid o SSI, pero ésta aún está pendiente después de 120 días, usted puede aprobar esta solicitud.



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

275 E Main St, 6W-A  
Phone: (502) 564-4321  
Fax: (502) 564-0509  
Frankfort, KY 40621  
www.chfs.ky.gov

**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

August 12, 2015

**IMPLEMENTATION OF ICD-10**

All Kentucky Medicaid Providers  
PL# A-100

Dear Kentucky Medicaid Provider:

The ICD-10 transition date is approaching quickly. As of October 1, 2015, providers are required to use ICD-10 codes in place of ICD-9 codes. The Department for Medicaid Services is offering assistance to our providers. It is essential that your practice be prepared for this transition because only claims coded with ICD-10 will be processed and paid for services on or after October 1, 2015

Are you prepared?

- Do you understand ICD-10 code sets and have a plan to utilize these codes in place of existing ICD-9 codes?
- Are you knowledgeable concerning the CMS rules regarding dates of service, how to handle claims spanning the October 1, 2015 implementation date?
- Do you bill electronically?
- Does your practice management software come with an ICD-10 upgrade?
- Do you need recertification for services requiring prior authorizations?

The Department's approach aligns with CMS guidelines as follows:

- No span-dated claims.
- Claims must be split, with the exception of inpatient hospital claims.
- Inpatient hospital claims will be processed using the discharge date, with dates of October 1, 2015 requiring ICD-10 codes.
- Claims will not be accepted if they have a combination of ICD-9 and ICD-10 codes.

For providers who bill electronically:

- Has your software vendor provide an ICD-10 upgrade?
- Some vendors provide updates to CPT/ICD codes periodically and some do not.
- In most cases, electronic claims are submitted using an automated software process.
- The Department continues to offer an opportunity for testing claims and files using ICD-10.



- Testing gives you the opportunity to ensure your claims will be processed and analyze the financial outcomes.

ICD-10 transition also impacts new prior authorizations and certifications. Any new prior authorization or new certification will require an ICD-10 diagnosis as of October 1, 2015. You will not need to obtain a new prior authorization if there is already an existing one in the system.

All Kentucky Medicaid fee-for-service providers have the opportunity to test with us before October 1, 2015. Contact us for details on testing opportunities at [ky\\_edi\\_helpdesk@hp.com](mailto:ky_edi_helpdesk@hp.com) and include ICD-10 Testing Collaboration in the subject line.

For further information and guidance on the upcoming ICD-10 transition, please visit the CMS ICD-10 website: <http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10>.

Sincerely,



Lisa D. Lee, Commissioner  
Department for Medicaid Services



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

275 E Main St, 6W-A  
Frankfort, KY 40621  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

August 12, 2015

**Important Information for all Medicaid Providers**

PL #A-101

Dear Medicaid Provider:

Beginning this month, you may see something new and different when checking for member eligibility in KyHealthNet. We are implementing three new member statuses that are outside of Medicaid eligibility. These status are Incarcerated (I), Warning (W), and Address Mismatch, eligible but disenrolled (A). Previously, Medicaid terminated eligibility for an incarcerated individual (I). Now these members will have their Medicaid eligibility suspended while incarcerated. During the suspension period, the Department is prohibited by federal rules from paying claims for these individuals.

All members with an (I) will be able to have their benefits re-instated when they are no longer incarcerated by simply logging onto their kynect account at [kynect.ky.gov](http://kynect.ky.gov), contacting the DCBS call center at 855-306-8959, calling the kynect call center at 855-459-6328, or working with a kynector. A list of available kynectors can also be found at [kynect.ky.gov](http://kynect.ky.gov). If a member has self-attested to being incarcerated, they may self-attest to being released. If not they will need to provide documentation but once verified they will be entitled to enroll in an MCO right away.

The Warning and Address mismatch status (W) is attached to a member when the Department receives undeliverable mail for these individuals. The W status only alerts the member and all providers that a member needs to log into kynect, call the DCBS call center, or the kynect call center and update their mailing address. Their eligibility status will remain unchanged while they are in the (W) status.

All members with a (W) status code will be dis-enrolled from the Medicaid program if they do not update their address prior to the last day of the month following the month in which they received the (W) status code. The (W) status code will be changed to an (A), indicating the member has been dis-enrolled and must update their address by simply logging onto their kynect account at [kynect.ky.gov](http://kynect.ky.gov), contacting the DCBS call center at 855-306-8959, calling the kynect call center at 855-459-6328, or working with a kynector. A list of available kynectors can also be found at [kynect.ky.gov](http://kynect.ky.gov).



The Department is making the address verification change to ensure that members are located and engaged in their healthcare delivery. The change also ensures that all individuals receiving services through Kentucky Medicaid actually live in the state, which is a condition of eligibility. Please encourage and assist those members in either the (W) or (A) status to make the necessary contact to update their address.

It is still important to remember that changes do not appear in real time across all systems so please check the system again if you are unsure of member status.

The Department remains committed to providing quality health care services to our members and this cannot be accomplished without our provider partners. Please contact Medicaid Provider Services at 855-824-5615 if you have specific questions on these new member statuses.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Lee".

Lisa D. Lee, Commissioner  
Department for Medicaid Services

LL/LG/kl

## Frequently Asked Questions: Address Mismatch Disenrollment

- When does this process become effective?
  - The process becomes active August 19, 2015 and includes Address Mismatch as well as Incarcerations suspension.
- Are there specific returned notices that trigger the Address Mismatch Disenrollment?
  - No, any piece of undeliverable mail will trigger this disenrollment.
- Who may update or change a member's address?
  - The member or authorized representative may update the address.
- How can an address be updated or changed?
  - Self Service Portal in kynect, DCBS call center at 855-306-8959 or kynect call center at 1-855-4kynect (459-6328).
  - MEDICAID MEMBER SERVICES DOES NOT HAVE ACCESS TO MAKE THESE CHANGES
- If a member officially notifies the United States Postal Service (USPS) of an address change and ask mail to be forwarded will DMS recognize this change by receipt of the forwarding notice?
  - The member has a duty to inform DMS through DCBS Call Center, kynect Call Center, or the Self Service Portal of any change in address. There is no authority to accept a change of address from a third party. Only if the mail is returned as undeliverable the warning record will be created.
- How long is the warning period for an address mismatch?
  - The warning period runs until the end of the second month after the record is created. For example if a warning record is created on August 20, 2015 the warning period runs till September 30, 2015.
- Will the member be allowed to re-enroll once the address is updated?
  - Yes. The member will be re-enrolled with their former Managed Care Organization (MCO) automatically if the disenrollment period was no longer than 60 days. If the disenrollment period was longer than 60 days, the member will be allowed to either choose an MCO or be auto-assigned an MCO.
- Will all DMS partners be able to handle a potential increase in call volume? Most of these changes will be brought about by members accessing care, so they will be time sensitive to both member and their providers.

- DMS is working with all partners, including providers, to implement this process as efficiently as possible.
- Can the member be notified upon enrollment of the need to notify if their address changes with the consequences if they don't comply?
  - Members are currently notified they have a duty to inform DCBS or kynect of any change in circumstances within 30 days or they may be terminated.

## Frequently Asked Questions: Incarcerated Individuals

- Can a currently incarcerated individual apply for and receive Medicaid after August 19, 2015?
  - Yes. Incarceration alone will no longer be a bar to eligibility. Federal regulations prevent Medicaid from paying for the health care of incarcerated individuals except in very limited circumstances. Previously, our eligibility systems were unable to implement this requirement and incarcerated individuals' Medicaid eligibility was terminated in order to comply. The new eligibility system can now accommodate this option.
- What does suspension for an incarcerated individual mean?
  - An incarcerated individual is not entitled to enrollment in an MCO or Fee For Service (FFS) claims payments except for admissions to hospitals for 24 hours or more.
- Does incarceration suspension disenroll the individual from their MCO until release?
  - Yes
- How will the incarceration suspension be lifted?
  - If the individual self attested to being incarcerated, they can also self attest to being released from incarceration. If the incarceration indicator was created by other means (Federal Hub for example) the individual must provide verification, i.e. release paper work, by uploading information in SSP, calling DCBS call center or kynect call center. Also see below for potential automation options.
- How will the system be informed the person has been released?
  - DMS is working with several partners in the corrections community to implement electronic information sharing. This could automate both incarceration and release.

**KyHealthNet Address Warning Message Example**

**KENTUCKY**  
**CABINET FOR HEALTH AND FAMILY SERVICES**  
KY MEDICAL MANAGEMENT INFORMATION SYSTEM (KYMMIS)

[Provider Home](#) | [Member](#) | [Claims](#) | [PA](#) | [Provider References](#) | [Trade Files](#) | [RA Viewer](#) | [EFT](#) | [Logout](#)

Member Eligibility Verification

Tuesday 14 July 2015 08:50 am

Provider:  - 282N00000X

Select Lookup Type:  Service Type:

Member ID:

From Date of Service:  To Date of Service:

**Member**

Current ID:  Last Name:  First Name:  Date of Birth:

Old ID:  Check Digit: 4 Gender: F Date of Death:

Other IDs Phone Number:

SSN:  County Code: 076 County Name: Madison

Address:

City: BEREA State: KY ZipCode: 40403-9717

Hospice Election Date:

Medicare A:  Medicare B:

Case Number:  Case Name:

**Suspensions/Disenrollments**

Address Mismatch Warning! Please call the Department for Community Based Services (DCBS) at 855-306-8959 or kconnect at 1-855-4kconnect (459-6328) to update your address.

Suspension/Disenrollment Type	Date Effective	Date End
W-ADDRESS MISMATCH WARNING	07/01/2015	07/30/2015

**Eligibility**

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization without Co-Pay	XC - Child	P1 - Child at least 6 and under 19, Attending School if 18	N	07/01/2015	07/30/2015
Coplay Indicator		From Date	To Date		
N		07/01/2015	07/30/2015		

**Note: POV\_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no**

**KyHealthNet A – Eligible but Disenrolled and I – Incarcerated indicator Message Example**

Suspensions/Disenrollments		
Suspension/Disenrollment Type	Date Effective	Date End
I-SUSPENDED - INCARCERATED	07/10/2015	07/12/2015
A-ELIGIBLE BUT DISENROLLED - ADDRESS MISMATCH	07/01/2015	07/30/2015

**Alert! Individuals with an incarceration suspension (Ind - I) or an address hold (Ind - A) will not be eligible for claims payment or MCO enrollment. If this information is incorrect, please call the Department for Community Based Services (DCBS) at 855-306-8959 or kconnect at 1-855-4kconnect (459-6328).**

Eligibility					
Eligibility 5 Year History					
Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
<u>KY Managed Care Organization without Co-Pay</u>	XC - Child	P1 - Child at least 6 and under 19, Attending School if 18	N	07.01/2015	07/30/2015