

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

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DEPARTMENT FOR MEDICAID SERVICES

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ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

Services by an Advanced Registered Nurse Practitioner shall be payable if the service provided is within the scope of licensure. These services shall include, however not be limited to, services provided by the certified nurse midwife (CNM), family nurse practitioner (FNP), and pediatric nurse practitioner (PNP).

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services provided ~~performed~~ in free-standing ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, fillings, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and Comprehensive Orthodontics are also available to recipients under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

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

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**EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)**

Under the EPSDT program, Medicaid-eligible children, from birth through the end of the birth month of their twenty-second birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Examination
- Growth and Development Assessment
- Hearing, Dental, and Vision Screenings
- Lab tests as indicated
- Assessment or Updating of Immunizations

**(EPSDT) SPECIAL SERVICES PROGRAM**

The EPSDT Special Services Program considers medically necessary items and services that are not routinely covered under the state plan. These services are for children from birth through the end of their twenty-first year. All services shall be prior authorized by the Department for Medicaid Services.

**FAMILY PLANNING SERVICES**

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

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

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### HEARING SERVICES

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

### HOME HEALTH SERVICES

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

### HOSPICE

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

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HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be preauthorized by a Peer Review Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age six (6) [one-(1)] in hospitals designated as disproportionate share hospitals by Kentucky Medicaid and services provided to recipients under age one (1) by all acute care hospitals.

OUTPATIENT SERVICES

Benefits of this Program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals covered, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

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LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky [Medicaid] participating [~~independent laboratories~~] providers includes all Medicaid covered procedures for which the provider [~~laboratory~~] is certified by the Clinical Laboratory Improvement Amendments (CLIA) requirements. [~~Medicare~~]

LONG TERM CARE FACILITY SERVICES

~~-NURSING-FACILITY-SERVICES~~

~~[The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.]~~

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (ICF/MR/DD)

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

The need for the ICF/MR/DD level of care shall be certified by the Kentucky Medicaid Peer Review Organization (PRO).

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

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~~[MENTAL-HOSPITAL-SERVICES]~~

~~[Reimbursement-is-available-for-inpatient-psychiatric-services-provided-to Medicaid-recipients-under-the-age-of-twenty-one-(21)-and-age-sixty-five (65)-or-older-in-a-psychiatric-hospital.--There-shall-be-no-limit-on-length of-stay; however, the-need-for-inpatient-psychiatric-hospital-services-shall be-verified-through-the-utilization-control-mechanism.]~~

MENTAL HEALTH SERVICES

COMMUNITY MENTAL HEALTH CENTER SERVICES

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

Outpatient Services  
~~[Partial-Hospitalization]~~ Psychosocial Rehabilitation  
 Emergency Services  
 Inpatient Services  
 Personal Care Home Visits

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

~~[NURSE-ANESTHETIST-SERVICES]~~

~~Anesthesia-services-performed-by-a-participating-Advanced-Registered-Nurse Practitioner-Nurse-Anesthetist-shall-be-covered-by-the-Kentucky-Medicaid Program.]~~

~~[NURSE-MIDWIFE-SERVICES]~~

~~Medicaid-coverage-shall-be-available-for-services-performed-by-a participating-Advanced-Registered-Nurse-Practitioner-Nurse-Midwife.--Covered services-include-an-initial-prenatal-visit, follow-up-prenatal-visits, delivery-and-up-to-two-(2)-follow-up-post-partum-visits-within-four-(4)-to six-(6)-weeks-of-the-delivery-date.]~~

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MENTAL HOSPITAL SERVICES

Reimbursement for inpatient psychiatric services shall be provided to Medicaid recipients under the age of twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facility services are limited to residents age six (6) to twenty-one (21). Program benefits are limited to eligible recipients who require inpatient psychiatric residential treatment facility services on a continuous basis as a result of a severe mental or psychiatric illness. There is no limit on length of stay; however, the need for inpatient psychiatric residential treatment facility services must be verified through the utilization control mechanism.

TARGETED CASE MANAGEMENT SERVICES

ADULTS Case management services are provided to recipients eighteen (18) years of age or older with chronic mental illness who need assistance in obtaining medical, educational, social, and other support services.

CHILDREN Case management services are provided to Severely Emotionally Disturbed (SED) children who need assistance in obtaining medical, educational, social, and other services.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

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**NURSE MIDWIFE SERVICES**

Medicaid reimbursement shall be available for covered services performed by and within the scope of practice of certified registered nurse midwives through the Advanced Registered Nurse Practitioner Program.

**PHARMACY SERVICES**

Legend and non-legend drugs from the approved Medical Assistance Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities. The Drug List is distributed periodically quarterly with monthly updates. Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization shall be[are] covered for payment through the Drug Preauthorization Program.

In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

**PHYSICIAN SERVICES**

Covered services include;

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

\*Appropriate consent forms shall [must] be completed prior to coverage of these procedures.

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Non-covered services include:

Most injections, [immunizations], supplies, drugs (except anti-neoplastic drugs), [~~selected vaccines and Rhogam; anti-neoplastic drugs~~], cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

Certain types of office exams, e.g. new patient [~~such as~~] comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

#### PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall be [~~is~~] covered only for certain medical conditions where the care requires professional supervision.

#### PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.

#### PRIMARY CARE SERVICES

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

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**RENAL DIALYSIS CENTER SERVICES**

~~[Renal]~~ Free-standing renal dialysis center ~~[service]~~ benefits include renal dialysis, certain supplies and home equipment.

**RURAL HEALTH CLINIC SERVICES**

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

**TRANSPORTATION SERVICES**

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

**VISION SERVICES**

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

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DEPARTMENT FOR MEDICAID SERVICES

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[PREVENTIVE HEALTH SERVICES

Preventive health services shall be provided by health departments or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.]

**\*\*SPECIAL PROGRAMS\*\***

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

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

The Alternative Intermediate Services for the Mentally Retarded (AIS/MR) home and community-based services project provides coverage for an array of community based services that shall be an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD).

HOME AND COMMUNITY BASED WAIVER SERVICES

A home and community-based services program provides Medicaid coverage for a broad array of home and community-based services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.

CONTINUATION, APPENDIX I, PAGE 11

KenPAC

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

~~The Alternative Intermediate Services for the Mentally Retarded [Mental Retard] (AIS/MR) home and community-based services project provides coverage for an array of community-based services that shall be an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DB).]~~

~~A home and community-based services program [project] provides Medicaid coverage for a broad array of home and community-based services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.]~~

**SPECIAL HOME- AND COMMUNITY-BASED SERVICES MODEL WAIVER PROGRAM**

The Model Waiver Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid recipients who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) recipients.

CONTINUATION, APPENDIX I, Page 11

[Hospice:--Medicaid-benefits-include-reimbursement-for-hospice-care-for  
Medicaid-recipients-who-meet-the-eligibility-criteria-for-hospice-care:  
Hospice-care-provides-to-the-terminally-ill-relief-of-pain-and-symptoms:  
Supportive-services-and-assistance-shall-also-be-provided-to-the-patient-and  
their-family-in-adjustment-to-the-patient's-illness-and-death.--A-Medicaid  
recipient-who-elects-to-receive-hospice-care-waives-all-rights-to-certain  
separately-available-Medicaid-services-which-shall-also-be-included-in-the  
hospice-care-scope-of-benefits.]

NEW FORM

CABINET FOR HUMAN RESOURCES  
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KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Name of members eligible for KMAP. Persons whose names are in this block have the Primary Care provider listed on this card.

**KENPAC MEDICAL ASSISTANCE IDENTIFICATION CARD**  
COMMONWEALTH OF KENTUCKY  
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD	CASE NUMBER	MEMBER NAME	MEMBER NUMBER	AGE	SEX
From 06-01-85 to 07-01-85	037 C 000123456	Smith, Jane	1234567890	2	0353 M
		Smith, Kim	2345678912	2	1284 M

Issue date: 12-27-80

Jane Smith  
400 Block Avenue  
Frankfort, Kentucky 40601

Warren Peace, M.D.  
1010 Tolstoy Lane  
Frankfort, KY 40601

Phone: 502-346-9832

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

Case name and address show to whom the card is billed. This person may be that of a relative or other interested party and may not be an eligible member.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Name, address and phone number of the Primary Care Physician.

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

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by the card. "From" date is first day of eligibility of the card. "To" date is the day eligibility of the card ends and is not included as an eligible day. KenPAC services provided during the eligibility period must be authorized by the Primary Care physician listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age

Names of members eligible for KMAAP. Persons whose names are in this block have the Primary Care provider listed on this card.

CARD card was issued	MEDICAL ASSISTANCE IDENTIFICATION CASE COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	AGE	DATE OF BIRTH MO. YR.	SEX
	ELIGIBILITY PERIOD	CASE NUMBER					
11/88	FROM: 08-01-88	187 C 000123456	Smith, Jane Smith, Karl	1234567890 2345678912	2	0353	M
	TO: 07-01-88					1284	F
	CASE NAME OR ADDRESS						
	JANE SMITH 400 Block Ave Frankfort, KY 40601						
	ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS						
	KENPAC PROVIDER AND ADDRESS						
	Warren Pease M.D. 1010 Hickory Lane Frankfort, KY 40601		502-348-9832 PHONE				

Case name and address show to whom the care is made. This person may be that of a relative or other interested party and may not be an eligible member.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Name, address and phone number of the Primary Care Physician.

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

(BACK OF CARD)

Information to Providers, including insurance identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage, and emergency care through the KenPAC system.

PROVIDERS OF SERVICE

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to sections (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to Cabinet for Human Resources, Department for Medicaid Services, Frankfort, Kentucky 40621.

Insurance Identification

- |  |                                     |
|--|-------------------------------------|
| A - Part A, Medicare Only Paid             | G - Champus                         |
| B - Part B, Medicare Only                  | H - Health Maintenance Organization |
| C - Both Parts A & B Medicare Premium Paid | J - Unknown                         |
| D - Blue Cross/Blue Shield                 | K - Other                           |
| E - Blue Cross/Blue Shield Major Medical   | L - Absent Parent's Insurance       |
| F - Private Medical Insurance              | M - None                            |
|  | N - United Mine Workers             |
|  | P - Black Lung                      |

RECIPIENTS OF SERVICES

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital (inpatient and outpatient), home health agency, laboratory, ambulatory surgical center, primary care center, rural health clinic, nurse anesthetist, durable medical equipment, and advanced registered nurse practitioner. Authorization by the primary provider is not required for ophthalmologists, psychiatric, and obstetrical services, or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show this card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient(s) temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

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

Recipient's signature is not required.

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

(BACK OF CARD)

Information to Providers including insurance identification codes which indicate type of insurance coverage as shown on the front of the card in the "block".

Information to Recipients including insurance coverage and emergency care through the KenPAC system.

**RECIPIENT OF SERVICES**  
The recipient of services is the person who receives services during the period specified on the reverse side of the card. The recipient of services is the person who is responsible for the payment of the cost of the services. The recipient of services is the person who is responsible for the payment of the cost of the services.

**PROVIDER OF SERVICES**  
The provider of services is the person who provides services during the period specified on the reverse side of the card. The provider of services is the person who is responsible for the payment of the cost of the services.

**INSURANCE IDENTIFICATION**

<input type="checkbox"/> A - Medicare Only	<input type="checkbox"/> G - Other
<input type="checkbox"/> B - Medicaid Only	<input type="checkbox"/> H - Medicaid/Medicare Dual Eligible
<input type="checkbox"/> C - Medicare/Medicaid	<input type="checkbox"/> I - Other (Specify)
<input type="checkbox"/> D - Medicare/Medicaid/Other	<input type="checkbox"/> J - Medicaid/Other
<input type="checkbox"/> E - Medicaid/Other	<input type="checkbox"/> K - Medicaid/Other
<input type="checkbox"/> F - Medicaid/Other	<input type="checkbox"/> L - Medicaid/Other
<input type="checkbox"/> G - Medicaid/Other	<input type="checkbox"/> M - Medicaid/Other
<input type="checkbox"/> H - Medicaid/Other	<input type="checkbox"/> N - Medicaid/Other
<input type="checkbox"/> I - Medicaid/Other	<input type="checkbox"/> O - Medicaid/Other
<input type="checkbox"/> J - Medicaid/Other	<input type="checkbox"/> P - Medicaid/Other
<input type="checkbox"/> K - Medicaid/Other	<input type="checkbox"/> Q - Medicaid/Other
<input type="checkbox"/> L - Medicaid/Other	<input type="checkbox"/> R - Medicaid/Other
<input type="checkbox"/> M - Medicaid/Other	<input type="checkbox"/> S - Medicaid/Other
<input type="checkbox"/> N - Medicaid/Other	<input type="checkbox"/> T - Medicaid/Other
<input type="checkbox"/> O - Medicaid/Other	<input type="checkbox"/> U - Medicaid/Other
<input type="checkbox"/> P - Medicaid/Other	<input type="checkbox"/> V - Medicaid/Other
<input type="checkbox"/> Q - Medicaid/Other	<input type="checkbox"/> W - Medicaid/Other
<input type="checkbox"/> R - Medicaid/Other	<input type="checkbox"/> X - Medicaid/Other
<input type="checkbox"/> S - Medicaid/Other	<input type="checkbox"/> Y - Medicaid/Other
<input type="checkbox"/> T - Medicaid/Other	<input type="checkbox"/> Z - Medicaid/Other

**RECIPIENT'S SIGNATURE**  
The recipient of services is required to sign the card at the time of service. The recipient's signature is required for the card to be valid. The recipient's signature is required for the card to be valid.

**PROVIDER'S SIGNATURE**  
The provider of services is required to sign the card at the time of service. The provider's signature is required for the card to be valid. The provider's signature is required for the card to be valid.

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

Recipient's signature is not required.

NEW  
FORM

APPENDIX III-B

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

CERTIFICATION ON LOBBYING (MAP-343 A)

MAP-343 A  
(11/91)

CERTIFICATION ON LOBBYING  
CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for such failure.

SIGNATURE: \_\_\_\_\_

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

NEW FORM

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 3/91)

Kentucky Medicaid Program  
Provider Information

1. \_\_\_\_\_ (Name) \_\_\_\_\_ (County)
2. \_\_\_\_\_  
(Location Address, Street, Route No, P.O. Box)
3. \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)
4. \_\_\_\_\_  
(Office Phone of Provider)
5. \_\_\_\_\_  
(Pay to, in care of, Attention, etc. if different from above address.)
6. \_\_\_\_\_  
Pay to address (if different from above)
7. Federal Employee ID No. \_\_\_\_\_
8. Social Security No. \_\_\_\_\_
9. License No. \_\_\_\_\_
10. Licensing Board (if applicable): \_\_\_\_\_
11. Original license date: \_\_\_\_\_
12. Kentucky Medicaid Provider No. (if known) \_\_\_\_\_
13. Medicare Provider No. (if applicable) \_\_\_\_\_
14. Practice Organization/Structure: \_\_\_\_\_ (1) Corporation  
\_\_\_\_\_ (2) Partnership \_\_\_\_\_ (3) Individual  
\_\_\_\_\_ (4) Sole Proprietorship \_\_\_\_\_ (5) Public Service Corporation  
\_\_\_\_\_ (6) Estate/Trust \_\_\_\_\_ (7) Government/Non-Profit
15. Are you a hospital based physician (salaried or under contract by a hospital)? \_\_\_\_\_ yes \_\_\_\_\_ no  
Name of hospital(s) \_\_\_\_\_

OLD FORM

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

KENTUCKY MEDICAL ASSISTANCE PROGRAM  
Provider Information

1. Name: \_\_\_\_\_
2. Street Address, P.O. Box, Route Number (In Care of, Attention, etc.): \_\_\_\_\_
3. City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
4. Area Code \_\_\_\_\_ Telephone Number \_\_\_\_\_
5. Pay to, In Care of, Attention, etc. (if different from above): \_\_\_\_\_
6. Pay to Address (if different from above): \_\_\_\_\_
7. Federal Employer ID Number: \_\_\_\_\_
8. Social Security Number: \_\_\_\_\_
9. License Number: \_\_\_\_\_
10. Licensing Board (if Applicable): \_\_\_\_\_
11. Original License Date: \_\_\_\_\_
12. MAP Provider Number (if known): \_\_\_\_\_
13. Medicare Provider Number (if Applicable): \_\_\_\_\_
14. Provider Type of Practice Organization:
 

<input type="checkbox"/> Corporation (Public)	<input type="checkbox"/> Individual Practice	<input type="checkbox"/> Hospital-Based Physician
<input type="checkbox"/> Corporation (Private)	<input type="checkbox"/> Partnership	<input type="checkbox"/> Group Practice
<input type="checkbox"/> Health Maintenance Organization	<input type="checkbox"/> Profit	<input type="checkbox"/> Non-Profit
15. If group practice, Number of Providers in Group (specify provider type): \_\_\_\_\_

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NEW FORM

APPENDIX IV-A

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

PROVIDER INFORMATION (MAP-344)

16. If group practice, number of providers in group (specify provider type):  
\_\_\_\_\_

17. If corporation, name, address, and telephone number of corporate office:  
\_\_\_\_\_  
Telephone No: \_\_\_\_\_  
Name and address of officers:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. If partnership, name and address of partners:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. National Pharmacy No. (If applicable):  
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)  
\_\_\_\_\_

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):  
1st \_\_\_\_\_ Date \_\_\_\_\_  
2nd \_\_\_\_\_ Date \_\_\_\_\_

21. Name of Clinic(s) in which Provider is a member:  
1st \_\_\_\_\_  
2nd \_\_\_\_\_  
3rd \_\_\_\_\_  
4th \_\_\_\_\_

22. Control of Medical Facility:  
\_\_\_ Federal \_\_\_ State \_\_\_ County \_\_\_ City  
\_\_\_ Charitable or religious  
\_\_\_ Proprietary (Privately-owned) \_\_\_ Other

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OLD FORM

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

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

Name: \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_

Name and Address of Officers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. If Partnership, name and address of Partners:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. National Pharmacy Number (if applicable):

(Seven-Digit Number Assigned by  
National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st \_\_\_\_\_

2nd \_\_\_\_\_

3rd \_\_\_\_\_

20. Physician/Professional Specialty Certifications:

1st \_\_\_\_\_

2nd \_\_\_\_\_

3rd \_\_\_\_\_

NEW FORM

APPENDIX IV-A

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

PROVIDER INFORMATION (MAP-344)

23. Fiscal Year End: \_\_\_\_\_

24. Administrator : \_\_\_\_\_ Telephone No. \_\_\_\_\_

25. Assistant Admin: \_\_\_\_\_ Telephone No. \_\_\_\_\_

26. Controller: \_\_\_\_\_ Telephone No. \_\_\_\_\_

27. Independent Accountant or CPA: \_\_\_\_\_  
Telephone No. \_\_\_\_\_

28. If sole proprietorship, name, address, and telephone number of owner:  
\_\_\_\_\_  
\_\_\_\_\_

29. If facility is government owned, list names and addresses of board members:  
President or Chairman of Board: \_\_\_\_\_  
Member: \_\_\_\_\_  
Member: \_\_\_\_\_

30. Management Firm (If applicable):  
\_\_\_\_\_

31. Lessor (If applicable):  
\_\_\_\_\_

32. Distribution of beds in facility:

	Total Licensed Beds	Total Kentucky Medicaid Certified Beds
Acute Care Hospital	_____	_____
Psychiatric Hospital	_____	_____
Nursing Facility	_____	_____
MR/DD	_____	_____

33. NF or MR/DD owners with 5% or more ownership:

Name	Address	% of Ownership
_____	_____	_____
_____	_____	_____
_____	_____	_____

OLD  
Form

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 08/85)

21. Physician/Professional Specialty Certification Board:

1st \_\_\_\_\_ Date: \_\_\_\_\_

2nd \_\_\_\_\_ Date: \_\_\_\_\_

3rd \_\_\_\_\_ Date: \_\_\_\_\_

22. Name of Clinic(s) in which Provider is a Member:

1st \_\_\_\_\_

2nd \_\_\_\_\_

3rd \_\_\_\_\_

4th \_\_\_\_\_

23. Control of Medical Facility:

Federal  State  County  City  Charitable or Religious

Proprietary (Privately Owned)  Other \_\_\_\_\_

24. Fiscal Year End: \_\_\_\_\_

25. Administrator: \_\_\_\_\_ Telephone No. \_\_\_\_\_

26. Assistant Administrator: \_\_\_\_\_ Telephone No. \_\_\_\_\_

27. Controller: \_\_\_\_\_ Telephone No. \_\_\_\_\_

28. Independent Accountant or CPA: \_\_\_\_\_ Telephone No. \_\_\_\_\_

29. If sole proprietorship, name, address, and telephone number of owner:

Name: \_\_\_\_\_

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

Telephone No. \_\_\_\_\_

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

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

NEW  
FORM

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

PROVIDER INFORMATION (MAP-344)

34. Institutional Review Committee Members (if applicable):  
\_\_\_\_\_  
\_\_\_\_\_

35. Providers of Transportation Services:  
Number of Ambulances in Operation: \_\_\_\_\_  
Number of Wheelchair Vans in Operation: \_\_\_\_\_  
Basic Rate \$ \_\_\_\_\_ (Includes up to \_\_\_\_\_ miles)  
Per Mile \$ \_\_\_\_\_ Oxygen \$ \_\_\_\_\_  
Extra Patient \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

36. Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider?  yes  no

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

Signature: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

Return all enrollment forms, changes and inquiries to:  
Medicaid-Provider Enrollment  
Third Floor East  
275 East Main Street  
Frankfort, KY 40621

INTER-OFFICE USE ONLY  
License Number Verified through \_\_\_\_\_ (Enter Code)  
Comments: \_\_\_\_\_  
Date: \_\_\_\_\_ Staff: \_\_\_\_\_

OLD  
FORM

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 02/85)

31. Management Firm (If Applicable):  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

32. Lessor (If Applicable):  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

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

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

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

Name	Address	Percent of Ownership
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OLD FORM

APPENDIX IV-A

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

PROVIDER INFORMATION (MAP-344)

35. Institutional Review Committee Members (If Applicable):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

36. Providers of Transportation Services:

No. of Ambulances in Operation: \_\_\_\_\_ No. of Wheelchair Vans in Operation: \_\_\_\_\_

Total No. of Employees: \_\_\_\_\_ (Enclose list of names, ages, experience & Training.)

Current Rates:

A. Basic Rate \$ \_\_\_\_\_ (Includes up to \_\_\_\_\_ miles.)

B. Per Mile \$ \_\_\_\_\_

C. Oxygen \$ \_\_\_\_\_ E. Other \_\_\_\_\_

D. Extra Patient \$ \_\_\_\_\_ \$ \_\_\_\_\_

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

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

INTER-OFFICE USE ONLY

License Number verified through \_\_\_\_\_ (Enter Code)

Comments: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Staff: \_\_\_\_\_

NEW  
FORM

APPENDIX X

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

THIRD PARTY LIABILITY PROVIDER LEAD FORM

(REV. 7/91)

THIRD PARTY LIABILITY  
LEAD FORM

Recipient Name : \_\_\_\_\_ MAID # \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Address: \_\_\_\_\_

Date of Service : \_\_\_\_\_ To: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

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

Policy #: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Date Filed with Carrier : \_\_\_\_\_

Provider Name : \_\_\_\_\_ Provider #: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OLD  
FORM

APPENDIX X

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

THIRD PARTY LIABILITY PROVIDER LEAD FORM

THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_ PROVIDER #: \_\_\_\_\_

RECIPIENT NAME: \_\_\_\_\_ MAID: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

DATE OF SERVICE: \_\_\_\_\_ TO: \_\_\_\_\_ DATE OF ADMISSION: \_\_\_\_\_

DATE OF DISCHARGE: \_\_\_\_\_ NAME OF INS. CO.: \_\_\_\_\_

POLICY #: \_\_\_\_\_ CLAIM NO: \_\_\_\_\_

AMOUNT OF EXPECTED BENEFITS: \_\_\_\_\_

MAIL TO: EDS  
Fiscal Agent for KAP  
ATTN: TPL Unit  
P.O. Box 2009  
Frankfort, Ky 40602

TRANSMITTAL #17

APPENDIX X

NEW  
FORM

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

CERTIFICATION OF CONDITIONS MET (MAP-346)

MAP-346  
(7/92)

KENTUCKY MEDICAID PROGRAM  
CERTIFICATION OF CONDITIONS MET  
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION  
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the Listed licensed medical professionals has entered into financial arrangements with \_\_\_\_\_  
(FACILITY NAME)

\_\_\_\_\_, for the purpose of providing  
(CITY) (STATE)  
his/her services to patients of this facility, and that currently on file in this facility is a Statement of Authorization (MAP-347) executed by each of these individuals which authorizes payment by the Kentucky Medicaid Program to \_\_\_\_\_  
(FACILITY) for services provided to eligible Kentucky Medicaid Program recipients.

NAME	PROFESSIONAL'S MEDICARE NUMBER	PROFESSIONAL'S LICENSE NUMBER	SPECIALTY	DATE OF FACILITY EMPLOYMENT
------	--------------------------------------	-------------------------------------	-----------	--------------------------------

SIGNATURE: \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

KENTUCKY MEDICAID  
Provider#: \_\_\_\_\_

CERTIFICATION OF CONDITIONS MET (MAP-346)

MAP-346  
(8/82)

KENTUCKY MEDICAL ASSISTANCE PROGRAM  
CERTIFICATION OF CONDITIONS MET  
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION  
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the following named licensed medical professionals  
is currently entered into financial arrangements with \_\_\_\_\_

(Facility Name)

\_\_\_\_\_, for the purpose of rendering his/her special  
(City) State,

services to patients of this facility, and that currently on file in this care center  
is a Statement of Authorization executed by each of these individuals which authorizes  
payment by the MAP to the \_\_\_\_\_ for

(Facility Name)

services rendered eligible Program beneficiaries.

<u>NAME</u>	<u>LICENSE NUMBER</u>	<u>POSITION (Physician, Psychologist, etc.)</u>	<u>DATE OF CENTER EMPLOYMENT</u>
-------------	---------------------------	---	--------------------------------------

Signed \_\_\_\_\_  
Facility Administrator

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

## HOSPITAL SERVICES MANUAL

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 CODING ADDENDUM
 

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INPATIENT REVENUE CODES	DESCRIPTION
423	Group Rate
424	Evaluation or Re-Evaluation
440	Speech Therapy, General
441	Visit Charge
442	Hourly Charge
443	Group Rate
444	Evaluation or Re-Evaluation
450	Emergency Room, General (For Services provided prior to June 1, 1991)
460	Pulmonary Function
470	Audiology, General
472	Treatment
480	Cardiology, General
481	Cardiac Cath Lab
482	Stress Test
610	MRI, General
611	Brain (including Brainstem)
612	Spinal Cord (including Spine)
621	Supplies Incident to Radiology
622	Supplies Incident to other Diagnostic Services
634	Erythropoietin (EPO) Less than 10,000 Units
635	Erythropoietin (EPO) 10,000 or More Units
636	Erythropoietin (EPO) Drug Requiring Detailed Coding
700	Cast Room, General
710	Recovery Room, General
720	Labor/Delivery Room, General
721	Labor
722	Delivery
723	Circumcision
724	Birthing Center (For services provided prior to June 1, 1991).
730	EKG/ECG, General
731	Holter Monitor
732	Telemetry (Includes fetal monitoring)
740	EEG, General
750	Gastro-Intestinal Services, General
760	Observation Room, General (For services provided prior to June 1, 1991).

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

## HOSPITAL SERVICES MANUAL

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 CODING ADDENDUM
 

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OUTPATIENT REVENUE CODES	DESCRIPTION
424	Physical Therapy, Evaluation or Re-Evaluation
440	Speech-Language Pathology, General
441	Speech-Language Path. - Visit Charge
442	Speech-Language Path. - Hourly Charge
443	Speech-Language Path. - Group Rates
444	Speech-Language Path. - Evaluation or Re-Evaluation
450	Emergency Room
460	Pulmonary Function
470	Audiology, General
471	Audiology, Diagnostic
472	Audiology, Treatment
480	Cardiology, General
481	Cardiac Cath, Lab
482	Stress Test
510	Clinic, General
512	Dental Clinic
610	MRI, General (Effective Date 11/25/85)
611	MRI, Brain (Effective Date 11/25/85)
612	MRI, Spine (Effective Date 11/25/85)
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
634	Erythropoietin (EPO) Less Than 10,000 Units
635	Erythropoietin (EPO) 10,000 or more Units
636	Erythropoietin (EPO) Drug Requiring Detailed Coding
700	Cast Room
710	Recovery Room
720	Labor Room/Delivery, General
721	Labor Room
722	Delivery Room
723	Circumcision
724	Birth Center
730	EKG/ECG (Electrocardiogram), General
731	Holter Monitor
732	Telemetry (Incl Fetal Monitoring)
740	EEG (Electroencephalogram), General
750	Gastro-Intestinal Service General

NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

---

ADVANCE DIRECTIVE LAW

---

DESCRIPTION OF KENTUCKY

ADVANCE DIRECTIVE LAW

In compliance with the mandate for Kentucky to develop a written description of its statutory and case law concerning advance directives, this office presents such a description below, which is based on statutory law, there being no case law which has specifically addressed the issue.

**KENTUCKY LAW ON ADVANCE DIRECTIVES FOR MEDICAL DECISIONS**

THE KENTUCKY LIVING WILL ACT

The 1990 session of the Kentucky General Assembly passed and the Governor signed into law House Bill No 113, known as the Kentucky Living Will Act, which is codified at KRS 311.622-644 and now sanctions the right of adult Kentuckians of sound mind to execute a written declaration which would allow life-prolonging treatments to be withheld or withdrawn in the event they become terminally ill and can no longer participate in making decisions about their medical care. The living will must be signed by the declarant in the presence of two subscribing witnesses who must not be blood relatives who would be beneficiaries of the declarant, beneficiaries of the declarant under the descent and distribution statutes of Kentucky, an employee of a health care facility in which the declarant is a patient, an attending physician of the declarant, or any person directly financially responsible for the declarant's health care. The living will must be notarized.

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NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

---

ADVANCE DIRECTIVE LAW

---

Two physicians, one of whom being the patient's attending physician, would have to certify that the declarant's condition was terminal before the living will could be implemented. The living will would not allow for the withholding or withdrawal of food or water, or medication or medical procedures deemed necessary to alleviate pain, and it would not apply to pregnant women.

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-986 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor:

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

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NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

---

ADVANCE DIRECTIVE LAW

---

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

PREPARED BY:

THE CABINET FOR HUMAN RESOURCES  
OFFICE OF GENERAL COUNSEL  
APRIL 22, 1991

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NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

ADVANCE DIRECTIVE LAW

DESIGNATION OF HEALTH CARE SURROGATE

I DESIGNATE \_\_\_\_\_ AS MY HEALTH CARE SURROGATE(S) TO  
MAKE ANY HEALTH CARE DECISIONS FOR ME WHEN I NO LONGER HAVE DECISIONAL CAPACITY.  
IF \_\_\_\_\_ REFUSES OR IS NOT ABLE TO ACT FOR ME,  
I DESIGNATE \_\_\_\_\_ AS MY HEALTH CARE SURROGATE(S).  
ANY PRIOR DESIGNATION IS REVOKED.  
SIGNED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 19\_\_\_\_

\_\_\_\_\_  
SIGNATURE AND ADDRESS OF THE GRANTOR

IN OUR JOINT PRESENCE, THE GRANTOR, WHO IS OF SOUND MIND AND EIGHTEEN YEARS OF  
AGE, OR OLDER, VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE DATED  
AND SIGNED FOR THE GRANTOR.

\_\_\_\_\_  
SIGNATURE AND ADDRESS OF WITNESS

\_\_\_\_\_  
SIGNATURE AND ADDRESS OF WITNESS

COMMONWEALTH OF KENTUCKY

\_\_\_\_\_ COUNTY

BEFORE ME, THE UNDERSIGNED AUTHORITY, CAME THE GRANTOR WHO IS OF SOUND  
MIND AND EIGHTEEN (18) YEARS OF AGE, OR OLDER, AND ACKNOWLEDGED THAT HE VOLUNTARILY  
DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE SIGNED AND DATED AS ABOVE.

DONE THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 19\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC

DATE COMMISSION EXPIRES: \_\_\_\_\_

NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

ADVANCE DIRECTIVE LAW

ADVANCE DIRECTIVE

ACKNOWLEDGMENT

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOC. SEC. #: \_\_\_\_\_

PLEASE READ THE FOLLOWING FIVE STATEMENTS:

Place your initials after each statement.

1. I have been given written materials about my right to accept or refuse medical treatment. \_\_\_\_\_ (Initialed)
2. I have been informed of my right to formulate advance directives. \_\_\_\_\_ (Initialed)
3. I understand that I am not required to have an advance directive in order to receive medical treatment. \_\_\_\_\_ (Initialed)
4. I understand that the terms of any advance directive that I have executed will be followed by my caregivers to the extent permitted by law. \_\_\_\_\_ (Initialed)
5. I understand that I can change my mind at any time and that my decision will not result in the withholding of any benefits or medical services. \_\_\_\_\_ (Initialed)

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

- I HAVE EXECUTED AN ADVANCE DIRECTIVE.
- I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE.

\_\_\_\_\_  
Patient/Guardian DATE: \_\_\_\_\_

\_\_\_\_\_  
Health Care Provider Representative DATE: \_\_\_\_\_

NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

ADVANCE DIRECTIVE LAW

PATIENT SELF-DETERMINATION PROTOCOL FOR CERTIFIED  
HEALTH CARE PROVIDERS

1. The Certified Health Care Provider shall inform all adult patients, in writing and orally, of information under Kentucky Law concerning their right to make decisions relative to their medical care.
2. The Certified Health Care Provider shall present each adult patient with a written copy of the agency's policy concerning implementation of their rights.
3. The Certified Health Care Provider shall not condition the provision of care or otherwise discriminate against any patient based on whether the patient has executed an advance directive.
4. The Certified Health Care Provider shall document in the patient's medical record whether or not the patient has executed an advance directive.
5. The Certified Health Care Provider shall ensure compliance with requirements of Kentucky Law concerning advance directives.
6. The Certified Health Care Provider shall educate all agency staff and the general public concerning advance directives.

NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

ADVANCE DIRECTIVE LAW

PATIENT SELF-DETERMINATION

Policy:

Advise all adult patients (a person eighteen [18] years of age or older and who is of sound mind) of their rights concerning advance directives. (According to provider type, i.e., admission, start of care, etc.)

Purpose:

1. To assure individuals understand they have the right to:
  - a. Accept or refuse medical or surgical treatment; and
  - b. Formulate advance directives.

Procedure:

Each Certified Health Care Provider shall:

1. Designate a person or persons responsible for informing adult patients of their right to make decisions concerning their medical care.
2. Distribute to each adult patient the following information:
  - a. The Cabinet for Human Resources' description of Kentucky Laws on Advance Directives.
  - b. Agency policy regarding implementation of advance directives.

NOTE: Recommend distribution of additional information to assist patients and/or staff in understanding advance directives. The following materials are acceptable:

"Advance Directives Issues and Answers"  
Hospice of the Bluegrass

"Advance Directives, Living Will, Health Care  
Surrogate, Durable Power of Attorney" Video  
Hospice of the Bluegrass

"About Advance Medical Directives"  
Channing Bete Co., Inc.

"Living Will"  
Division of Aging Services

NEW FORM

APPENDIX XXI

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

ADVANCE DIRECTIVE LAW

PATIENT SELF-DETERMINATION (Continued)

"Planning For Difficult Times - Tomorrow's Choices"  
"Planning For Difficult Times - A Matter of Choice"  
American Association of Retired Persons

3. Maintain *Living Will and Designation of Health Care Surrogate* documents for distribution to adult patients upon request.
4. Documentation supporting compliance with the requirements regarding non-discriminatory care shall be incorporated into the Quality Assurance process.
5. Documentation supporting the patient's decision to formulate an advance directive shall be included in the medical record. (Recommend use of attached *Advance Directive Acknowledgment Form*.) A process shall be developed to assure appropriate staff are advised of the patient's directive.
6. Documentation supporting all aspects of the staff and general public education campaign shall be recorded by appropriate personnel.
7. Stipulate by policy, family members or guardians will be provided with information regarding advance directives when the patient is comatose or otherwise incapacitated and unable to receive the information. Once he or she is no longer incapacitated the information must be provided directly to the adult patient.



**EXPLANATION OF CHANGES-INCORPORATED MATERIAL**

**907 KAR 1:376**

**HOSPITAL SERVICES MANUAL**

**OCTOBER, 1992**

1. The Hospital Services Manual is used by agency staff and participating providers of the Medicaid Program. This Manual is being amended to reflect any significant policy and billing changes which have been promulgated and approved in the appropriate administrative regulation governing the specific subject matter, and to show any minor clarifications of policy or procedure which may be made.
2. The entire manual consists of one hundred ninety-seven (197) pages. One hundred twenty-two (122) pages are being amended by this proposed regulation.
3. The Table of Contents is being amended to add, delete, and change headings to reflect the correct sections and page contents. These changes have no major impact on policy.

**Reason:** This action was taken to reflect correct location of page and section content.

**Authority:** KRS 205.520

4. Page 1.1 is being amended to delete the inappropriate EDS toll-free telephone number and adding the new toll-free number and deleting "Medical Assistance" and adding "Medicaid" to correctly identify the Kentucky Medicaid Program.

**Reason:** To correctly identify the Kentucky Medicaid Program and provide correct telephone number for EDS.

**Authority:** KRS 205.520

5. Page 2.1 is being amended to delete the phrase "frequently referred to as the Medicaid Program", deleted "Medical Assistance" and added "Medicaid" to correctly identify the Program and deleting the phrase "either by Medicare or Medicaid" to clarify Program coverage.

Reason: To provide correct Program identity and coverage provided in this manual.

Authority: KRS 205.520

6. Pages 2.2 is being amended to correct the number of required advisory council members from "17" to "18", four-year term appointees from "16" to "17", members representing the professional groups changed from "9" to "10", and the addition of "3" which clarifies the number representing the lay citizens. In addition, "3" was added to clarify the frequency of each council meeting.

Reason: To provide the correct number of members required to form the Advisory Council.

Authority: KRS 205.540, KRS 205.520

7. Pages 2.3 is being amended by adding "(5) or six (6)" to correct the members needed to represent provider groups and recipients. This page also includes information transferred from previous page.

Reason: To provide the correct number of members required to form the Advisory Council.

Authority: KRS 205.540, KRS 205.520

8. Page 2.4-2.5 are being amended by transferring information from previous pages. There are no actual changes involved.

Reason: Retyping of pages required due to the transferring of information to different pages.

Authority: KRS 13A, KRS 205.520

9. Page 2.6 is being amended to contain a paragraph transferred from previous page and the addition of phrase: "having knowledge of the occurrence of any event affecting" which was inadvertently omitted in the previous manual update.

Reason: To meet requirements of Public Law 92-603, Section 1909.

Authority: KRS 13A, KRS 205.520

10. Page 2.7-2.8 are being amended to including information transferred from previous pages. There are no policy changes involved.

Reason: To meet KRS 13A drafting requirements.

Authority: KRS 13A, KRS 205.520

11. Page 2.9 is being amended to delete "445.45" to 447.45" and to include information transferred from previous page.

Reason: To meet KRS 13A drafting requirements.

Authority: KRS 13A, KRS 205.520

12. Page 2.10 is being amended to include information from previous page and by deleting "refugee cases" to clarify program policy.

Reason: To verify deletion of Refugee cases from coverage.

Authority: KRS 13A, KRS 205.520

13. Page 2.11 is being amended to include information transferred from previous page and by adding "Advanced Registered Nurse Practitioner" to updated with Program services.

Reason: To meet drafting changes and provide latest Program service categories.

Authority: KRS 13A, KRS 205.520

14. Page 2.12 is being amended to include information transferred from previous page and changing "will" to "shall", "is" to "shall" and adding "be" to comply with LRS regulations.

Reason: To meet KRS 13A drafting changes.

Authority: KRS 13A, KRS 205.520

15. Page 2.13 is being amended to include information from previous page and "will" and "can" to "shall" to comply with LRS regulations.

Reason: To meet KRS 13A drafting changes.

Authority: KRS 13A, KRS 205.520

16. Page 3.1 is being amended to include the phrases "(Medicare) in order to be eligible to submit a Commonwealth of" which was inadvertently omitted on the previous manual updated and adding "Department for Medicaid Services Certification on Lobbying (MAP-343A)" to comply with Program policy.

Reason: To clarify and provide clear requirements for provider participation.

Authority: KRS 13A, KRS 205.520

17. Page 3.2 is being amended by deleting "Intermediate Care Facility Manual or Skilled Nursing Facility Manual" and adding Nursing Facility Services Manual. The last sentence was transferred from following page.

Reason: To provide the latest revision of Program service titles.

Authority: KRS 205.520, KRS 13A

18. Page 3.3 is being amended by changing "Medical Assistance" to "Medicaid" for correct Program identification, deleting "Review" in order to correctly identify the Peer Review Organization and transferring information from the following page.

Reason: To clarify Program and Peer Review Organization identity.

Authority: KRS 205.520

19. Page 3.4 is being amended by adding "Standard" to clarify the time zone and transferring of information from the following page.  
Reason: To clarify the area time zone.  
Authority: KRS 205.520
20. Page 3.5 is being amended to include information transferred from the following page.  
Reason: To meet drafting regulations.  
Authority: KRS 13A, KRS 205.520
21. Page 3.6 is being amended by changing "must" to "shall" to comply with LRC regulations, "Medical Assistance" to "Medicaid" for appropriate Program identification and the inclusion of written information being transferred from the following page.  
Reason: To correctly identify the Medicaid Program and meet KRS 13A drafting regulations.  
Authority: KRS 13A, KRS 205.520
22. Pages 3.7-3.8 are being amended to include regulations involving the Patient's Advance Directives as established in OBRA, 1990, Section 4751.  
Reason: To comply with OBRA 1990 regulations.  
Authority: OBRA 90, KRS 205.520
23. Page 4.1-4.8 are being amended to include new federally mandated coverage; therefore, each page contains information which was transferred from a prior page.  
Reason: To meet drafting requirements.  
Authority: KRS 205.520, KRS 13A

24. Page 4.1 is being amended by changing "the" to "either", "date" to "the first day" and adding "if later" to clarify Program policy; "can" and "will" to "shall" to meet LRC requirements and paragraphs relating to Program policy concerning coverage for recipients under age 6 in disproportionate share hospitals and under age 1 in non-disproportionate share hospitals.

Reason: To meet drafting requirements and provide additional Program coverage relating to recipients under the ages of six (6) and one (1) as required by OBRA '90.

Authority: KRS 13A, KRS 205.520, OBRA '90

25. Page 4.2 is being amended to include additional information relating to services covered under the Hospital Indigent Care Assurance Program (HICAP). Other corrections include the deletion of "can", "is", "are", and adding "shall" or "shall be" to comply with LRC regulations.

Reason: To provide updated information involving HICAP and other drafting changes.

Authority: KRS 205.570, KRS 205.520, KRS 13A

26. Page 4.3 is being amended to include the phrase, "The services shall be considered covered, subject to other Program edits," which was inadvertently omitted from prior manual updates. Other corrections include the deletion of "are" to "shall be" to comply with LRC regulations and "3" to "30".

Reason: To meet KRS 13A drafting requirements.

Authority: KRS 13A, KRS 205.520

27. Page 4.4 is being amended to change "handicapped individuals" to "persons with disabilities" and "is" to "shall be".

Reason: To clarify and meet drafting requirements.

Authority: KRS 13A, KRS 205.520

28. Page 4.6 is being amended to delete "will" and add "shall" to comply with LRC regulations.

Reason: To meet KRS 13A drafting requirements.

Authority: KRS 13A, KRS 205.520

29. Page 4.8 is being amended by adding the phrase "Effective for services provided prior to July 1, 1991, in order to reflect implementation date for coverage.

Reason: To meet KRS 13A drafting requirements.

Authority: KRS 13A, KRS 205.520

30. Page 4.9 is being amended by deleting the phrase "on or after July 1, 1989" and adding "from July 1, 1989 through June 30, 1991", to clarify Program policy and deleting "are" and adding "shall be" to comply with LRC regulations. Other corrections include the addition of two paragraphs relating to federally mandated Program services provided on or after July 1, 1991, to recipients under age 6 in disproportionate share hospitals and to recipients under age 1 in non-disproportionate share hospitals.

Reason: To meet drafting requirements and to comply with new federally mandated Program coverage issues.

Authority: KRS 13A, KRS 205.520, OBRA '90

31. Page 4.10 is being amended by deleting "such" and adding "that" for correct grammar.

Reason: To meet KRS 13A drafting requirements.

Authority: KRS 13A, KRS 205.520

32. Page 4.12 is being amended to include a paragraph relating to Clinical Laboratory Improvement Amendments (CLIA). Other corrections include deleting "their" and adding "its" for correct grammar.

Reason: To meet Clinical Laboratory Improvement Amendments of '88 and other drafting requirements.

Authority: KRS 13A, KRS 205.520, CLIA '88

33. Page 4.13 is being amended by deleting "disproportionate share" and adding "Acute", "Medicaid", "with exceptionally high costs or long lengths of stay" and "under age six (6) for disproportionate hospitals" to clarify Program policy.

Reason: To clarify Program coverage as it relates to recipients with exceptionally high costs or long lengths of stay.

Authority: KRS 13A, KRS 205.520, OBRA '90

34. Page 4.15 is being amended by deleting "services" to clarify Program policy.

Reason: To meet KRS 13A drafting requirements.

Authority: KRS 13A, KRS 205.520

35. Page 4.16 is being amended by adding a paragraph relating to Clinical Laboratory Improvement Amendments (CLIA).

Reason: To meet Clinical Laboratory Improvement Amendments of '88.

Authority: KRS 13A, KRS 205.520. CLIA '88

36. Page 4.17 is being added and will include item 10 concerning policy on observation room and holding beds which was inadvertently omitted from the prior update and deleting "are" and adding "shall be" to comply with LRC regulations.

Reason: To meet drafting requirements and provide Program coverage clarification.

Authority: KRS 13A, KRS 205.520

37. Page 5.2 is being amended to include a paragraph clarifying Program policy relating to the billing of outpatient services provided prior to the actual time of the inpatient admission.

Reason: To provide current Program coverage.

Authority: KRS 13A, KRS 205.520

38. Page 5.3 is being amended by deleting the inappropriate address for ordering the CPT-4 books and adding the correct address.

Reason: To meet drafting requirements.

Authority: KRS 13A, KRS 205.520

39. Page 5.4 is being amended by deleting "Rendered" for clarification purposes and "its" and adding "their" for correct grammar.

Reason: To meet drafting requirements.

Authority: KRS 13A, KRS 205.520

40. Page 5.5 is being amended by deleting paragraphs relating to the MAP-346. This paragraph now appears on page 5.6.

Reason: To meet drafting requirements.

Authority: KRS 13A, KRS 205.520

41. Page 5.6 is being amended to include paragraphs relating to the MAP-346 which was transferred from the prior page and by adding "provided" under item #7 to clarify Program policy.

Reason: To meet drafting requirements and provide additional Program coverage.

Authority: KRS 13A, KRS 205.520

42. Page 5.7 is being amended by deleting "will" and adding "shall" to comply with LRC regulations.

Reason: To meet drafting requirements.

Authority: KRS 13A, KRS 205.520

43. Page 5.8 is being amended by adding "Effective" in last paragraph for clarification of Program coverage.

Reason: To clarify the effective date of Program coverage for out-of-state hospitals.

Authority: KRS 13A, KRS 205.520

44. Page 5.10 is being amended by adding a paragraph relating to the add-on fee which has been established for out-of-state disproportionate share hospitals.
- Reason: To meet drafting requirements and provide additional Program coverage.
- Authority: KRS 13A, KRS 205.520
45. Page 6.1 is being amended by deleting "MCAA" and adding "MCCA" to correctly identify the Medicare Catastrophic Coverage Act (MCCA).
- Reason: To correctly identify the Medicare Catastrophic Coverage Act (MCCA).
- Authority: KRS 13A, KRS 205.520, MCCA '88
46. Page 6.2 is being amended by deleting the last paragraph which is being transferred to the following page.
- Reason: To meet drafting requirements.
- Authority: KRS 13A, KRS 205.520
47. Page 6.3 is being amended to include the first paragraph which was transferred from the prior page and by deleting "Rendered for clarification purposes.
- Reason: To meet drafting requirements.
- Authority: KRS 13A, KRS 205.520
48. Pages 6A.1-6A.7 are being amended to include additions, deletions, or the rearranging of information which required the transferring of information to different pages.
- Reason: To comply with drafting requirements.
- Authority: KRS 13A, KRS 205.520
49. Page 6A.1 is being amended by deleting "Medical Assistance" and adding "Medicaid" for correct Program identity.
- Reason: To comply with drafting requirements.
- Authority: KRS 13A, KRS 205.520

50. Page 6A.2 is being amended by adding insurance codes K, R, S, and their meaning and a sentence in the last paragraph to clarify policy involving third party payor coverage verification.

Reason: To provide current insurance codes and detailed information required when the recipients have exhausted their third party coverage.

Authority: KRS 13A, KRS 205.520

51. Page 6A.3 is being amended by adding continued clarification of services involving third party payors.

Reason: To provide current Program requirements involving recipients that have exhausted their third party benefits and information necessary before Program payment can be provided.

Authority: KRS 205.520, KRS 13A

52. Page 6A.4 is being amended by deleting the incorrect EDS toll-free telephone number and entering the correct toll-free number.

Reason: To provide the current telephone numbers of EDS for provider contact purposes.

Authority: KRS 205.520

53. Page 6A.7 is being amended by deleting "attorney", "company" to "carrier", adding "party, but the liability has not been determined, you shall proceed with submitting your claim to EDS if you provide" and deleting "for payment shall be pursued from the liable party. If the liable party has not been determined, attach copies of" and "the claim when submitting to Medicaid for payment." in order to clarify Program policy concerning accident and work related claims.

Reason: To provide current requirements to providers when submitting claims that involve services billed as a result of an accident or work-related incident.

Authority: KRS 205.520

54. Pages 7.1-7.24 are being amended to include additions, deletions, and transferring of information to various pages in order to clarify Program policy and billing instructions.

Reason: To clarify Program policy and billing instructions.

Authority: KRS 205.520, KRS 13A

55. Page 7.1 is being amended to delete "carbon" for clarification purposes. In addition, the fourth paragraph is being deleted and transferred to page 7.5 for billing clarification purposes.

Reason: To correct minor changes and transfer the fourth paragraph to item "F" to better describe the completion of the UB-82 billing form.

Authority: KRS 205.520

56. Page 7.2 is being amended to delete inappropriate EDS toll-free telephone number and enter the correct toll-free number.

Reason: To provide the current telephone number of EDS for provider contact purposes.

Authority: KRS 205.520

57. Page 7.3 is being amended to include three paragraphs relating to the billing of Part A and Part B services that are transmitted via tape to Kentucky Medicaid by the Medicare fiscal intermediary.

Reason: To provide Program policy concerning the implementation of the Medicare Part A and B tape billing and billing procedure that follows if claims do not appear on the Medicaid RA's within thirty (30) days of the Medicare adjudication date.

Authority: KRS 205.520

58. Page 7.4 is being amended by deleting "such" and adding "these" for clarification purposes. Other additions include information relating to Outpatient services provided prior to admission as an inpatient.

Reason: To meet drafting requirements and provide Program policy concerning the billing of outpatient services prior to the actual time of admission as an inpatient.

Authority: KRS 13A, KRS 205.520

59. Page 7.5 is being amended by including continued information relating to outpatient services provided prior to actual admission, changing "E" to "F" and the addition of a paragraph describing form locator instructions for the UB-82 billing form which was transferred from page 7.1.

Reason: To provide updated Program policy involving outpatient services and to clarify UB-82 instructions.

Authority: KRS 205.520

60. Page 7.6 is being amended to include "regular Medicaid" for billing clarification and a paragraph relating to the usage of TOB 134.

Reason: To clarify different billing procedures for regular Medicaid outpatient services and a paragraph relating to the usage of TOB 134.

Authority: KRS 205.520

61. Page 7.8 is being amended by deleting "one (1)" and adding "six (6)" and "COVERED" to clarify Program policy.

Reason: To clarify the Program policy in relation to recipients under the age six (6) in disproportionate share hospitals and the entry for the covered dates of service.

Authority: KRS 205.520, OBRA '90

62. Page 7.9 is being amended by adding a paragraph relating to the billing of regular outpatient services and recurring outpatient services in accordance with Program policy. In addition, "covered" is being included to clarify the days to be billed to Medicaid for reimbursement.

Reason: To clarify Program coverage in billing for recurring outpatient services and request to enter COVERED days in appropriate area on the billing form.

Authority: KRS 205.520

63. Page 7.11 is being amended to include updated information regarding the usage of CPT-4 codes required through 1992.

Reason: To provide the appropriate usage of CPT-4 codes through the year of 1992.

Authority: KRS 205.520, HCPCS '92

64. Page 7.12 is being amended to include the phrase "and shall be identified as Kentucky Medicaid or KY Medicaid" in order to properly identify the Medicaid Program.

Reason: To comply with drafting requirements and correctly identify the Medicaid Program.

Authority: KRS 205.520, KRS 13A

65. Page 7.13 is being amended by deleting "Exception: MAID numbers of refugee recipients will include alpha characters" as Medicaid no longer covers these services.

Reason: To update Program policy as refugee services are no longer covered by Kentucky Medicaid.

Authority: KRS 205.520

66. Page 7.15 is being amended by deleting "state, name and license numbers" and adding "Unique Physician Identification Number (UPIN) and name" to comply with Medicare guidelines.

Reason: To update Program records by adding a request for the Unique Physician Identification Number (UPIN) to comply with Medicare guidelines.

Authority: KRS 205.520, HCFA

67. Page 7.16 is being amended by deleting "must" and adding "shall" to comply with LRC drafting regulations.

Reason: To comply with drafting requirements.

Authority: KRS 13A, KRS 205.520

68. Page 7.19 is being amended by adding "July 1, 1991 through June 30, 1991", for individuals under age one (1) and two additional paragraphs concerning disproportionate share and non-disproportionate share information relating to recipients under ages of 6 and 1 which relates to Program coverage.

Reason: To provide the effective date and changes involving recipients under age six (6) in disproportionate share hospitals and under age one (1) in all acute care hospitals.

Authority: KRS 205.520, OBRA '90

69. Pages 7.21-7.24 are being added in order to provide billing instructions for the HCFA-1500 that the providers are required to utilize when billing the Medicaid Program for the Part B deductible and coinsurance amounts covering hospital-based physician services.

Reason: To provide billing instructions for the HCFA-1500 that the providers are required to utilize when billing for the Part B deductible/coinsurance amounts covering hospital-based physician services.

Authority: KRS 205.520

70. Page 9.2 is being amended by deleting the inappropriate EDS toll-free telephone number and adding the new toll-free number.

Reason: To provide the correct toll-free telephone number of EDS for provider contact purposes.

Authority: KRS 205.520

71. Page 9.4 is being amended by deleting the inappropriate EDS toll-free telephone number and adding the correct toll-free number. Other corrections include deleting "ID" and adding "Identification" for clarification purposes.

Reason: To provide the correct toll-free telephone number for EDS for provider contact purposes and adding identification for clarification in reference to the Medical Assistance Identification Card.

Authority: KRS 205.520

72. Page 9.7 is being amended by deleting the inappropriate EDS toll-free telephone number and adding the correct number and "such" to "this" for clarification purposes.

Reason: To comply with drafting regulations and provide the correct toll-free telephone number of EDS for provider contact purposes.

Authority: KRS 13A, KRS 205.520

73. Appendix I, pages 1-11, are being amended by deleting, adding, and rearranging the summaries of services covered by the Medicaid Program in alphabetical order for easier reference.

Reason: Services covered by the Medicaid Program were rearranged in alphabetical order for easier reference.

Authority: KRS 205.520

74. Appendix I, Page 1 is being amended by including a description of Advanced Registered Nurse Practitioner Services, deleting "performed" and adding "provided", "free-standing" under Ambulatory Surgical Center Services and "a" to "suppliers of" for clarification of services provided by the Medicaid Program.

Reason: To comply with drafting requirements and provide a clear explanation of Program coverage.

Authority: KRS 205.520, KRS 13A

75. Appendix I, Page 2 is being amended to include a summary of services provided under EPSDT Special Services Program.

Reason: To provide Program coverage.

Authority: KRS 205.520

76. Appendix I, page 3 is being amended by deleting "are" to "shall be" in order to comply with LRC regulations, "certain hearing aid repairs shall be covered through the hearing services element", "aid" to "aide" and "durable medical equipment, appliances, and certain prosthetic supplies on a preauthorized basis" to clarify Program coverage. Other additions include Medicaid benefits available under Hospice care.

Reason: To comply with drafting requirements and provide a clear explanation of Program coverage.

Authority: KRS 13A, KRS 205.520

77. Appendix I, Page 4 is being amended to include a sentence under Hospital Inpatient Services verifying elective and cosmetic services, services provided to recipients under age one (1) and changing "one (1)" to reflect "six (6)" in accordance with Program coverage.

Reason: To provide a clear explanation of Program coverage.

Authority: KRS 205.520

78. Appendix I, Page 5 is being amended by rearranging the wording of laboratory services to comply with CLIA requirements, deleting and relocating Nursing Facility Services and adding "for the Mentally Retarded and Developmentally Disabled (ICF/MR/DD)" for coverage clarification.

Reason: To comply with CLIA requirements and clarify Program coverage.

Authority: KRS 205.520, CLIA '88

79. Appendix I, Page 6 is being amended by deleting "Partial Hospitalization" and adding "Psychosocial Rehabilitation". Other changes include deleting information pertaining to Mental Hospital Services, Nurse Anesthetist Services, and Nurse Midwife Services as this information was transferred to other pages.

Reason: To provide a clear explanation of Program coverage.

Authority: KRS 205.520

80. Appendix I, Page 8 is being amended by changing "quarterly" to "periodically", "are" to "shall be" and "must" to "shall" to comply with LRC regulations. Other changes include the addition of selected vaccines and RhoGAM as a covered item under Physician Services and information regarding Nurse Midwife Services.

Reason: To comply with drafting requirements and provide a clear explanation involving Program coverage.

Authority: KRS 13A, KRS 205.520

81. Appendix I, Page 9 is being amended by deleting "immunizations", "selected vaccines and RhoGAM, anti-neoplastic drugs", "such as" to "e.g. new patient" to clarify coverage benefits and "is" to "shall be" to comply with LRC regulations.

Reason: To comply with drafting requirements and provide clear explanations involving Program coverage.

Authority: KRS 13A, KRS 205.520

82. Appendix I, Page 10 is being amended by deleting "Renal" and "services" to correctly identify the Renal Dialysis Center Services.

Reason: To clarify Program coverage available for recipients receiving services in Renal Dialysis Centers.

Authority: KRS 205.520

83. Appendix II-C, Pages 1-2 are being amended by deleting the old KenPAC eligibility card and replacing it with the new card.

Reason: To provide current KenPAC eligibility information which denotes services applicable to the KenPAC Program.

Authority: KRS 205.520

84. Appendix III-B is being added to include the Certification on Lobbying Form (MAP-343A) which is a new form that is required for Provider Enrollment purposes.

Reason: To provide a copy of a form that is now required by Provider Enrollment.

Authority: KRS 205.520

85. Appendix IV-A, Pages 1-4 are being amended by deleting the old form, MAP-344 (Rev. 08/85), and replacing it with the new MAP-344 form (Rev. 03/91).

Reason: To provide the new MAP-344 form (Rev. 03/91) which is required for Provider Enrollment purposes.

Authority: KRS 205.520

86. Appendix IV-A, Page 5 is being deleted as it is no longer required because the new form only has a total of four (4) pages.

Reason: The new MAP-344 form (Rev. 03/91) only contains four pages; therefore, this page is obsolete.

Authority: KRS 205.520

87. Appendix X is being amended by deleting the old Third Party Lead Form and replacing it with the new Third Party Lead Form (Rev. 07/91).

Reason: To enable the providers of medical services to provide EDS/Medicaid, when needed, more detailed information regarding third party involvement.

Authority: KRS 205.520

88. Appendix XI is being amended by deleting the old MAP-346 form (Rev. 08/82) and replacing it with the new MAP-346 (Rev. 07/92).

Reason: To provide the Program with additional information needed to process Medicare Part B crossover services.

Authority: KRS 205.520

89. Appendix XIX, Page 5 is being amended to include Revenue Code 636-Erythropietin (EPO) Drug Requiring Detailed Coding which is now a covered item.

Reason: To denote that the EPO drug is now a covered item under hospital inpatient services.

Authority: KRS 205.520

90. Appendix XXI, Page 11 is being amended to include Revenue Code 636-Erythropietin (EPO) Drug Requiring Detailed Coding which is now a covered item.

Reason: To denote that the EPO drug is now a covered item under hospital outpatient services.

Authority: KRS 205.520

91. Appendix XXI, Page 1-9 are being added to provide information to providers in reference to the Advance Directive Law.

Reason: To comply with OBRA 1990 regulations.

Authority: KRS 205.520, OBRA '90

92. Appendix XXII is being added to provide a copy of the HCFA-1500 billing form.

Reason: To provide a copy of claim form that the providers are required to utilize when billing for the Part B deductible/coinsurance amounts covering hospital-based physician services.

Authority: KRS 205.520.

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:376  
INCORPORATION BY REFERENCE OF THE  
HOSPITAL SERVICES MANUAL

SUMMARY OF INCORPORATED MATERIAL

October, 1992

1. The Hospital Services Manual is used by agency staff and participating providers of the Medicaid Program. This Manual is being amended to reflect any significant policy and billing changes which have been promulgated and approved in the appropriate administrative regulation governing the specific subject matter, and to show any minor clarifications of policy or procedure which may be made.
2. The entire manual consists of one hundred ninety-seven (197) pages. One hundred twenty-two (122) pages are being amended by this proposed regulation. The changes are listed below.
3. The Table of Contents is being amended to add, delete, and change headings to reflect the correct sections and page contents. These changes have no major impact on policy.
4. Page 1.1 is being amended to delete the inappropriate EDS toll-free telephone number and adding the new toll-free number and deleting "Medical Assistance" and adding "Medicaid" to correctly identify the Kentucky Medicaid Program.
5. Page 2.1 is being amended to delete the phrase "frequently referred to as the Medicaid Program", deleted "Medical Assistance" and added "Medicaid" to correctly identify the Program and deleting the phrase "either by Medicare or Medicaid" to clarify Program coverage.
6. Page 2.2 is being amended to correct number of required advisory council members from "17" to "18", four-year term appointees from "16" to "17", members representing the professional groups changed from "9" to "10", and the addition of "3" which clarifies the number representing the lay citizens. In addition, "3" was added to clarify the frequency of each council meeting.
7. Page 2.3 is being amended by adding "(5) or six (6)" to correct the members needed to represent provider groups and recipients. This page also includes information transferred from previous page.
8. Pages 2.4-2.5 are being amended by transferring information from previous pages. There are no actual changes involved.

9. Page 2.6 is being amended to contain a paragraph transferred from previous page and the addition of phrase: "having knowledge of the occurrence of any event affecting" which was inadvertently omitted in the previous manual update.
10. Pages 2.7-2.8 are being amended to include information transferred from previous pages. There are no policy changes involved.
11. Page 2.9 is being amended to delete "445.45" to "447.45" and to include information transferred from previous page.
12. Page 2.10 is being amended to include information from previous page and by deleting "refugee cases" to clarify Program policy.
13. Page 2.11 is being amended to include information transferred from previous page and by adding "Advanced Registered Nurse Practitioner" to update with Program Services.
14. Page 2.12 is being amended to include information transferred from previous page and changing "will" to "shall", "is" to "shall" and adding "be" to comply with LRC regulations.
15. Page 2.13 is being amended to include information from previous page and "will" and "can" to "shall" to comply with LRC regulations.
16. Page 3.1 is being amended to include the phrases "(Medicare) in order to be eligible to submit a Commonwealth of" which was inadvertently omitted on the previous manual update and adding "Department for Medicaid Services Certification on Lobbying (MAP-343A)," to comply with Program Policy.
17. Page 3.2 is being amended by deleting "Intermediate Care Facility Manual or Skilled Nursing Facility Manual" and adding Nursing Facility Services Manual. The last sentence was transferred from following page.
18. Page 3.3 is being amended by changing "Medical Assistance" to "Medicaid" for correct Program identification, deleting "Review" in order to correctly identify the Peer Review Organization and transferring information from the following page.
19. Page 3.4 is being amended by adding "Standard" to clarify the time zone and transferring of information from the following page.
20. Page 3.5 is being amended to include information transferred from the following page.

21. Page 3.6 is being amended by changing "must" to "shall" to comply with LRC regulations, "Medical Assistance" to "Medicaid" for appropriate Program identification and the inclusion of written information being transferred from the following page.
22. Pages 3.7-3.8 are being amended to include regulations involving the Patient's Advance Directives as established in OBRA, 1990, Section 4751.
23. Page 4.1-4.18 are being amended to include new federally-mandated Program coverage; therefore, each page contains information which was transferred from a prior page.
24. Page 4.1 is being amended by changing "the" to "either", "date" to "the first day" and adding "if later" to clarify Program policy; "can" and "will" to "shall" to meet LRC requirements and paragraphs relating to Program policy concerning coverage for recipients under age 6 in disproportionate share hospitals and under age 1 in non-disproportionate share hospitals.
25. Page 4.2 is being amended to include additional information relating to services covered under the Hospital Indigent Care Assurance Program (HICAP). Other corrections include the deletion of "can", "is", "are", and adding "shall" or "shall be" to comply with LRC regulations.
26. Page 4.3 is being amended to include the phrase, "The services shall be considered covered, subject to other Program edits," which was inadvertently omitted from prior manual updates. Other corrections include the deletion of "are" to "shall be" to comply with LRC regulations and "3" to "30".
27. Page 4.4 is being amended to change "handicapped individuals" to "persons with disabilities" and "is" to "shall be".
28. Page 4.6 is being amended to delete "will" and add "shall" to comply with LRC regulations.
29. Page 4.8 is being amended by adding the phrase "Effective for services provided prior to July 1, 1991, in order to reflect implementation date for coverage."

30. Page 4.9 is being amended by deleting the phrase "on or after July 1, 1989" and adding "from July 1, 1989 through June 30, 1991: to clarify Program policy and deleting "are" and adding "shall be" to comply with LRC regulations. Other corrections include the addition of two paragraphs relating to federally mandated Program services provided on or after July 1, 1991, to recipients under age 6 in disproportionate share hospitals and to recipients under age 1 in non-disproportionate share hospital.
31. Page 4.10 is being amended by deleting "such" and adding "that" for correct grammar.
32. Page 4.12 is being amended to include a paragraph relating to Clinical Laboratory Improvement Amendments (CLIA). Other corrections include deleting "their" and adding "its" for correct grammar.
33. Page 4.13 is being amended by deleting "disproportionate share" and adding "Acute", "Medicaid", "with exceptionally high costs or long lengths of stay" and "under age six (6) for disproportionate hospitals" to clarify Program policy.
34. Page 4.15 is being amended by deleting "services" to clarify Program policy.
35. Page 4.16 is being amended by adding a paragraph relating to Clinical Laboratory Improvement Amendments (CLIA).
36. Page 4.17 is being added and will include item 10 concerning policy on observation room and holding beds which was inadvertently omitted from the prior update and deleting "are" and adding "shall be" to comply with LRC regulations.
37. Page 5.2 is being amended to include a paragraph clarifying Program policy relating to the billing of outpatient services provided prior to the actual time of the inpatient admission.
38. Page 5.3 is being amended by deleting the inappropriate address for ordering the CPT-4 books and adding the correct address.
39. Page 5.4 is being amended by deleting "Rendered" for clarification purposes and "its" and adding "their" for correct grammar.

40. Page 5.5 is being amended by deleting paragraphs relating to the MAP-346. This paragraph now appears on page 5.6.
41. Page 5.6 is being amended to include paragraphs relating to the MAP-346 which was transferred from the prior page and by adding "provided" under item #7 to clarify Program policy.
42. Page 5.7 is being amended by deleting "will" and adding "shall" to comply with LRC regulations.
43. Page 5.8 is being amended by adding "Effective" in last paragraph for clarification of Program coverage.
44. Page 5.10 is being amended by adding a paragraph relating to the add-on fee which has been established for out-of-state disproportionate share hospitals.
45. Page 6.1 is being amended by deleting "MCAA" and adding "MCCA" to correctly identify the Medicare Catastrophic Coverage Act of 1988.
46. Page 6.2 is being amended by deleting the last paragraph which is being transferred to the following page.
47. Page 6.3 is being amended to include the first paragraph which was transferred from the prior page and by deleting "Rendered" for clarification purposes.
48. Pages 6A.1-6A.7 are being amended to include additions, deletions, or the rearranging of information which required the transferring of information to different pages.
49. Page 6A.1 is being amended by deleting "Medical Assistance" and adding "Medicaid" for correct Program identity.
50. Page 6A.2 is being amended by adding insurance codes K, R, S, and their meaning and a sentence in the last paragraph to clarify policy involving third party payor coverage verification.
51. Page 6A.3 is being amended by adding continued clarification of services involving third party payors.
52. Page 6A.4 is being amended by deleting the incorrect EDS toll-free telephone number and entering the correct toll-free number.

53. Page 6A.7 is being amended by deleting "attorney", "company" to "carrier", adding "party, but the liability has not been determined, you shall proceed with submitting your claim to EDS if you provide" and deleting "for payment shall be pursued from the liable party. If the liable party has not been determined, attach copies of" and "the claim when submitting to Medicaid for payment." in order to clarify Program policy concerning accident and work related claims.
54. Pages 7.1-7.24 are being amended to include additions, deletions, and transferring of information to various pages in order to clarify Program policy and billing instructions.
55. Page 7.1 is being amended to delete "carbon" for clarification purposes. In addition, the fourth paragraph is being deleted and transferred to page 7.5 for billing clarification purposes.
56. Page 7.2 is being amended to delete inappropriate EDS toll-free telephone number and enter the correct toll-free number.
57. Page 7.3 is being amended to include three paragraphs relating to the billing of Part A and Part B services that are transmitted via tape to Kentucky Medicaid by the Medicare fiscal intermediary.
58. Page 7.4 is being amended by deleting "such" and adding "these" for clarification purposes. Other additions include information relating to Outpatient services provided prior to admission as an inpatient.
59. Page 7.5 is being amended by including continued information relating to outpatient services provided prior to actual admission, changing "E" to "F" and the addition of a paragraph describing form locator instructions for the UB-82 billing form which was transferred from page 7.1.
60. Page 7.6 is being amended to include "regular Medicaid" for billing clarification and a paragraph relating to the usage of TOB 134.
61. Page 7.8 is being amended by deleting "one (1)" and adding "six (6)" and "COVERED" to clarify Program policy.

62. Page 7.9 is being amended by adding a paragraph relating to the billing of regular outpatient services and recurring outpatient services in accordance with Program policy. In addition, "covered" is being included to clarify the days to be billed to Medicaid for reimbursement.
63. Page 7.11 is being amended to include updated information regarding the usage of CPT-4 codes required through 1992.
64. Page 7.12 is being amended to include the phrase "and shall be identified as Kentucky Medicaid or KY Medicaid" in order to properly identify the Medicaid Program.
65. Page 7.13 is being amended by deleting "Exception: MAID numbers of refugee recipients will include alpha characters" as Medicaid no longer covers these services.
66. Page 7.15 is being amended by deleting "state, name and license numbers" and adding "Unique Physician Identification Number (UPIN) and name" to comply with Medicare guidelines.
67. Page 7.16 is being amended by deleting "must" and adding "shall" to comply with LRC drafting regulations.
68. Page 7.19 is being amended by adding "July 1, 1991 through June 30, 1991", "for individuals under age one (1)} and two additional paragraphs concerning disproportionate share and non-disproportionate share information relating to recipients under ages of 6 and 1 which relates to Program coverage.
69. Pages 7.21-7.24 are being added in order to provide billing instructions for the HCFA-1500 that the providers are required to utilize when billing the Medicaid Program for the Part B deductible and coinsurance amounts covering hospital-based physician services.
70. Page 9.2 is being amended by deleting the inappropriate EDS toll-free telephone number and adding the new toll-free number.
71. Page 9.4 is being amended by deleting the inappropriate EDS toll-free telephone number and adding the correct toll-free number. Other corrections include deleting "ID" and adding "Identification" for clarification purposes.
72. Page 9.7 is being amended by deleting the inappropriate EDS toll-free telephone number and adding the correct number and "such" to "this" for clarification purposes.

73. Appendix I, pages 1-11, are being amended by deleting, adding, and rearranging the summaries of services covered by the Medicaid Program in alphabetical order for easier reference.
74. Appendix I, page 1 is being amended by including a description of Advanced Registered Nurse Practitioner Services, deleting "performed" and adding "provided", "free-standing" under Ambulatory Surgical Center Services and changing "may" to "shall" and "supplier or supplier of" and "a" to "suppliers of" for clarification of services provided by the Medicaid Program.
75. Appendix I, page 2 is being amended to include a summary of services provided under EPSDT Special Services Program.
76. Appendix I, page 3 is being amended by deleting "are" to "shall be" in order to comply with LRC regulations, "certain hearing aid repairs shall be covered through the hearing service element", "aid" to "aide" and "durable medical equipment, appliances and certain prosthetic supplies on a preauthorized basis" to clarify Program coverage. Other additions include Medicaid benefits available under Hospice care.
77. Appendix I, page 4 is being amended to include a sentence under Hospital Inpatient Services verifying elective and cosmetic services, services provided to recipients under age one (1) and changing "one (1)" to reflect "six (6)" in accordance with Program coverage.
78. Appendix I, page 5 is being amended by rearranging the wording of laboratory services to comply with CLIA requirements, deleting and relocating Nursing Facility Services and adding "for the Mentally Retarded and Developmentally Disabled (ICF/MR/DD)" for coverage clarification.
79. Appendix I, page 6 is being amended by deleting "Partial Hospitalization" and adding "Psychosocial Rehabilitation". Other changes include deleting information pertaining to Mental Hospital Services, Nurse Anesthetist Services, and Nurse Midwife Services as this information was transferred to other pages.

80. Appendix I, page 8 is being amended by changing "quarterly" to "periodically", "are" to "shall be" and "must" to "shall" to comply with LRC regulations. Other changes include the addition of selected vaccines and RhoGAM as a covered item under Physician Services and information regarding Nurse Midwife Services.
81. Appendix I, page 9 is being amended by deleting "immunizations", "selected vaccines and RhoGAM, anti-neoplastic drugs", "such as" to "e.g. new patient" to clarify coverage benefits and "is" to "shall be" to comply with LRC regulations.
82. Appendix I, page 10 is being amended by deleting "Renal" and "services" to correctly identify the Renal Dialysis Center Services.
83. Appendix II-C, pages 1-2 are being amended by deleting the old KenPAC eligibility card and replacing it with the new card (Rev. 11/91).
84. Appendix III-B is being added to include the Certification on Lobbying Form (MAP-343 A) which is a new form that is required for Provider Enrollment purposes.
85. Appendix IV-A, pages 1-4 are being amended by deleting the old form MAP-344 (Rev. 08/85) and replacing it with the new MAP-344 form (Rev. 03/91).
86. Appendix IV-A, page 5 is being deleted as it is no longer required because the new form only has a total of four (4) pages.
87. Appendix X is being amended by deleting the old Third Party Lead Form and replacing with the new Third Party Lead Form (Rev. 07/91).
88. Appendix XI is being amended by deleting the old MAP-346 form (Rev. 08/82) and replacing it with the new MAP-346 (Rev. 07/92).
89. Appendix XIX, page 5 is being amended to include Revenue Code 636-Erythropietin (EPO) Drug Requiring Detailed Coding which is now a covered item.
90. Appendix XIX, page 11 is being amended to include Revenue Code 636-Erythropietin (EPO) Drug Requiring Detailed Coding which is now a covered item.

91. Appendix XXI, pages 1-9 are being added to provide information to providers in reference to the Advance Directive Law.
92. Appendix XXII is being added to provide a copy of the HCFA-1500 billing form.