NOTE: As a result of the Medicare Catastrophic Coverage Act of 1988 (MCCA), effective February 1, 1989, the Medicaid Program shall provide reimbursement for all Medicare deductible and coinsurance amounts for those individuals who are concurrently Medicare beneficiaries and Medicaid recipients. Reimbursable services shall be limited to coinsurance and deductibles for all Medicare (Parts A and B) covered services or items regardless of whether the services or items are covered by Kentucky Medicaid.

B. Physician Services by Hospital-Based Physicians

Under the Medicaid Program, hospital-based physicians are defined in the same manner as in PRINCIPLES OF REIMBURSEMENT FOR SERVICES [~~RENDERED~~] BY HOSPITAL-BASED PHYSICIANS (HIM-6).

The Medicaid Program shall pay Part B deductible and coinsurance for professional component in accordance with Program policies, procedures and benefits.

C. Primary Liability

When a recipient is receiving benefits from Title XVIII and Title XIX, Title XVIII accepts primary liability for all payment sought.

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

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

A. General

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

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

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

B. Identification of Third Party Resources

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

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

recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT, OR INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

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

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

A - Part A, Medicare only
B - Part B, Medicare only
C - Both Parts A and B Medicare
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private medical insurance
G - Champus
H - Health Maintenance Organization
J - [~~Other and/or u~~]Unknown
K - Other
L - Absent Parent's insurance
M - None
N - United Mine Workers
P - Black Lung
R - Part A, Medicare Premium Paid
S - Both Parts A and B Medicare Premium Paid

C. Private Insurance

If the recipient has third party resources, then the provider shall obtain payment or rejection from the third party before Medicaid can be billed. When payment is received, the provider shall indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy number(s) of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim. This rejection notice shall consist of recipient's name, date of service, termination or effective date of coverage, statement of benefits available (if applicable) and signature of the insurance representative or the letter shall be on the insurance company's letterhead.

The insurance company remittance statement can be used to verify coverage. It shall consist of recipient name, dates of service, indication of denial or that the billed amount was applied to the deductible.

NOTE: Denials from insurance carriers stating additional information is necessary to process claims shall not be acceptable as verification of coverage.

Exceptions:

*If the other insurance company, including CHAMPUS, has not responded within 120 days of the date a claim is submitted to the insurance company, submit with the Medicaid claim a copy of the completed TPL Form and indicate [~~other insurance claim indicating~~] "NO RESPONSE IN 120 DAYS" on the [~~Medicaid claim~~] form. The Medicaid claim form and the[~~Then forward a~~] completed TPL Lead Form shall be submitted to:

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

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

*A letter from the provider indicating that XYZ insurance company has been contacted and an agent verified that the recipient was not covered, can also be attached to the Medicaid claim. The letter shall include the name of the insurance company, address, phone number and the agent's name and telephone number (or notation indicating a voice automated response system was reached) as well as the recipient's name, MAID number and dates of service in question ,the termination or effective date of coverage and statement of benefits available (if applicable).

D. Medicaid Payment for Claims Involving a Third Party

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

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

(800) 756-7557 [~~333-2188~~]
or
(502) 227-2525

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

The amount paid by the third party shall be applied to any non-covered days or services and any remaining monies shall reduce the Medicaid Program payment. If the third party payment exceeds the Medicaid allowed amount, the resulting Medicaid Program payment shall be zero. Recipients cannot be billed for any difference in covered charges and the Medicaid payment amount. All providers have the choice in determining if this type of service shall be billed to the Kentucky Medicaid Program; however, if the Medicaid Program is billed for the service, then Program guidelines shall be followed. As a result, providers shall accept Medicaid payment as payment in full.

Detailed below are sample Medicaid payment methodologies for in-state and out-of-state inpatient hospital services. These payment formulas can be used to determine the amount due on any inpatient admission which is greater than fourteen days with third party involvement.

EXAMPLE 1 - Pricing example for in-state hospitals using a per diem rate:

Step 1:	$ 470.33	Medicaid Per Diem Rate
	x 14	Days Payable
	$6,584.62	Medicaid Maximum Payment
Step 2:	$36,592.11	Total charges for 24 day stay (entire stay)
	-25,150.67	Billed charges for covered period
	$11,441.44	TPL Balance
	-11,913.10	Amount received from other source
	$ -471.66	TPL balance. If this amount is negative, Medicaid payment is reduced. If the amount is positive, Medicaid payment is not reduced
Step 3:	$ 6,584.62	Amount payable
	- 471.66	TPL Balance
	$ 6,112.96	Amount due from the Medicaid Program

EXAMPLE 2 - Pricing example for out-of-state hospitals using percentage of charges:

Step 1:	$20,550.00	Billed charges for 14 day covered period
	- 200.00	Non-covered charges
	$20,350.00	Covered charges for days payable
	x 75%	Reimbursement rate
	$15,262.50	Medicaid maximum payment
Step 2:	$36,000.00	Total charges for total stay (20 days)
	-20,550.00	Total charges for covered stay
	$15,450.00	
	-19,000.00	Amount received from other sources
	$-3,550.00	TPL Balance. If this amount is negative, Medicaid payment is reduced. If the amount is positive, Medicaid payment is not reduced

Step 3:

$15,262.50	Medicaid maximum payment
-3,550.00	TPL balance
$11,712.50	Amount due from Medicaid if paid using percentage as rate.

Step 4: The computed payment is compared against the maximum rate for in-state hospitals of comparable bed size using payment formula for instate hospitals. Final Medicaid payment will be the lower of the two formulas

NOTE: If there is no third party involvement only Step 1 is necessary under either payment formula.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim shall be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated on the remittance statement. The provider shall pursue payment with this third party resource before billing Medicaid again. Itemized statements shall be stamped "Medicaid Assigned" when they are forwarded to insurance companies, attorneys, recipients, etc.

E. Amounts Collected from Other Sources

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

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

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

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

F. Accident and Work Related Claims

For claims billed to the Medicaid Program that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an [~~attorney,~~] employer, individual or an insurance carrier[~~company~~] is a liable party, but the liability has not been determined, you shall proceed with submitting your claim to EDS if you provide [~~for payment, payment shall be pursued from the liable party. If the liable party has not been determined, attach copies of~~] any information obtained, such as the names of attorneys, other involved parties and or the recipient's employer. [~~the claim when submitting to Medicaid for payment.~~]

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

VII. COMPLETION OF INVOICE FORM

A. General

The UB-82 invoice shall be used to bill for services provided in an acute care hospital to eligible Medicaid recipients. Typing of the invoice form is strongly urged, since an invoice cannot be processed unless the information supplied is complete and legible.

The original of the UB-82 shall be submitted to EDS as soon as possible after services are provided. A [~~carbon~~] copy shall be retained by the provider.

All UB-82 invoices shall be sent to:

EDS
P.O. Box 2045
Frankfort, KY 40602

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

[~~Following are form locator by form locator instructions for billing Medicaid Services on the UB 82 billing statement. Only instructions for form locators required for EDS processing or the Medicaid Program information are included. Instructions for form locators not used by EDS or the Medicaid Program processing can be found in the UB 82 Training Manual. The UB-82 Training Manual may be obtained from the Kentucky Hospital Association, P.O. Box 24163, Louisville, Kentucky 40224. You may also obtain the UB 82 billing forms from the above address.~~]

It is extremely important that the ancillary services reported on the UB-82 billing form be submitted by using the correct Revenue Codes. All approved Revenue Codes are listed in Appendix XIX. Incorrect billing of ancillary services or failure to correct any errors may ultimately affect of the instate provider's prospective payment rate.

If the admission involves a payment from a third party payor, an itemized or summarized bill shall be attached to each UB-82 for admissions which contain non-covered days.

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

B. Electronic Media Claims (EMC)

Acute care hospitals are now allowed to submit regular claims via electronic media. Providers shall continue using paper claims for all crossover services or any claim which requires attachments. For detailed information regarding EMC billing, contact: EDS, P.O. Box 2009, Frankfort, Kentucky 40602 or call 1-(800)- 756-7557 [~~333-2188~~] or (502) 227-2525.

C. Medicare Deductibles and Coinsurance

Billing for Medicare Part A deductible or coinsurance days, Medicare Part B deductible or coinsurance and Title XIX services shall be on separate claim forms. Example: If the recipient was covered by Medicare Part A, Medicare Part B and Medicaid, three separate claims shall be submitted for payment of the three types of benefits. A Medicare Explanation of Benefits or Remittance Advice shall be attached to EACH UB-82.

Medicaid PRO certification is not required on Medicare deductible and coinsurance claims as certification was determined using Medicare guidelines. If all Medicare benefits are exhausted and Title XIX days are being billed, then Medicaid PRO certification for those Medicaid days shall be necessary.

Effective for claims processed on and after October 12, 1991, the Medicare Division of Blue Cross/Blue Shield, Louisville, Kentucky began transmitting Medicare Part A and B claims directly to the Medicaid Program via tape. If a claim does not appear on the Medicaid Remittance Statement within thirty (30) days of the Medicare adjudication date, a paper UB-82 with the corresponding Medicare Remittance Advice shall be submitted to the Medicaid Program.

Effective for claims processed on and after September 13, 1991, the Medicare Division of Blue Cross/Blue Shield, Lexington, Kentucky began transmitting Medicare Part B claims covering hospital-based physicians (i.e., emergency room physician, anesthesiologist, cardiologist, etc.) directly to the Medicaid Program via tape. If a claim does not appear on the Medicaid Remittance Statement within thirty (30) days of the Medicare adjudication date, a paper HCFA-1500 (Rev. 12\90) with the corresponding Medicare Explanation of Benefits shall be submitted to the Kentucky Medicaid Program for processing in accordance with billing instructions contained in Section VII, G.

Providers utilizing a Medicare fiscal intermediary other than those listed above shall continue to submit all Medicare Cross-over claims using paper UB-82s or HCFA-1500s with the corresponding Medicare Remittance Advice or EOMB to each claim.

D. Unassigned Medicare/Medicaid Claims

If Medicaid is to be billed for Medicare deductible or co-insurance amounts for Medicare Part A or Part B services provided on and after April 1, 1990, the provider of services shall accept assignment. Unassigned claims shall be denied by Kentucky Medicaid.

The Medicaid Program shall not make payment on an unassigned claim for services provided prior to April 1, 1990 unless the claim was filed with Medicare without knowledge by the provider of the recipient's eligibility for Medicaid or QMB benefits.

These[~~Such~~] claims can be processed as follows:

1. The Medicare amount paid shall be refunded to Medicare and any payment made by the recipient shall be refunded to the recipient

or

2. The hospital can submit to EDS the Explanation of Medicare Benefits (EOMB), the UB-82, and a letter signed by the authorized representative of the hospital stating the following:

   a. The recipient had paid the hospital only the amount allowed by Medicare minus any deductible and coinsurance amounts. If the recipient has paid the deductible or coinsurance amounts or both, that payment shall be refunded to the recipient prior to billing Kentucky Medicaid.

   b. The amount paid by the recipient and by Medicaid shall be considered payment in full.

   c. The hospital did not have knowledge of the recipient's Medicaid eligibility at the time the Medicare claim was filed.

   By submitting the letter, the hospital accepts assignment.

E. Outpatient Services Provided Prior to Admission as Inpatient

Effective for services provided on and after June 1, 1991, the Kentucky Medicaid Program requires that all outpatient services provided prior to the actual admission as an inpatient be submitted on a separate billing claim from the claim for inpatient services. This policy change has created problems involving Medicaid recipients who have only Part B of Medicare because this billing procedure is not utilized by Medicare. Medicare requires all charges, both inpatient and outpatient,

be submitted on one claim as an inpatient service. As a result, the provider and the beneficiary\recipient are left with charges being denied by both Medicare and Medicaid.

In order to eliminate this problem, the Program has implemented Type of Bill 134 along with special system edits that will identify these cases and permit them to be processed. Your facility should utilize this Type of Bill (TOB) when you encounter charges (i.e., emergency room, drugs, supplies, etc.) for services that are being denied because Medicare considers them to be inpatient services, the individual does not have Medicare Part A coverage but is eligible for Kentucky Medicaid benefits. Type of Bill 134 is effective for services provided on and after June 1, 1991.

In addition, the facility shall enter the phrase "outpatient charges not covered by Medicare" in Form Locator #94 on the UB-82 billing form when claims are submitted to the Kentucky Medicaid Program for payment. This notation will help identify the reason the services were submitted without the usual Medicare Remittance Advice.

[E.]F. UB-82 Billing Instructions

Following are form-locator by form-locator instructions for billing Medicaid Services on the UB-82 billing statement. Only instructions for form locators required for EDS processing or the Medicaid Program information are included. Instructions for form locators not used by EDS or the Medicaid Program processing can be found in the UB-82 Training Manual. The UB-82 Training Manual may be obtained from the Kentucky Hospital Association, P.O. Box 24163, Louisville, Kentucky 40224. You may also obtain the UB-82 billing forms from the above address.

F.L.1 PROVIDER NAME, ADDRESS AND TELEPHONE

Enter the complete name and address of the facility. The telephone number, including area code, is desired.

F.L.3 PATIENT CONTROL NUMBER

Enter the patient control number (must be numeric) assigned by the facility. The first seven digits will appear on the Remittance Statement.

F.L.4 TYPE OF BILL

Enter the appropriate 3-digit code to indicate the type of bill.

1st Digit (Type of facility)	1 = Hospital
2nd Digit (Bill Classification	1 = Inpatient (including Medicare Part A) 2 = Inpatient (Medicare Part B only) 3 = Outpatient 4 = Non-patient
3rd Digit (Frequency)	0 = Non-payment 1 = Admit through Discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 Interim, final claim

NOTE: The 3rd digit for regular Medicaid outpatient services will always be a 1.

TOB 134 has been established and shall be used to accomodate services (i.e., emergency room, observation room, etc.) provided to recipients with only Part B of Medicare coverage that were admitted as an inpatient through the outpatient department. Please refer to Section VII, item #E for further instruction.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.8 MEDICAID PROVIDER NUMBER

Enter the assigned 8-digit KENTUCKY Medicaid provider number.

F.L.15 ADMISSION DATE

Enter the date of actual admission to the facility in month, day, year numeric format.

F.L.16 ADMISSION HOUR

Enter the code for the time of admission to the facility, BOTH INPATIENT AND OUTPATIENT.

CODE STRUCTURE

CODE	TIME A.M.	CODE	TIME P.M.
00	12:00 - 12:59 midnight	12	12:00 - 12:59 noon
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

F.L.17 TYPE OF ADMISSION (Inpatient only)

Enter the appropriate code for type of inpatient admission.

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn

F.L.21 PATIENT STATUS (Inpatient only)

Enter the appropriate 2 digit patient status code indicating patient disposition at the time of the billing for the given period of care. Refer to the UB-82 Training Manual for detailed codes and explanations.

F.L. 22 STATEMENT COVERS PERIOD

The Medicaid Program shall reimburse the facility up to the maximum of fourteen (14) COVERED days per admission.

EXCEPTIONS: Hospitals designated by Kentucky Medicaid as disproportionate share hospitals are not limited to the 14 day maximum when billing for services provided to recipients under age six (6) [one-(1)] . In these cases, days are unlimited, however, each calendar month of service shall be billed on separate billing forms.

Medicare and Medicaid crossover services are not limited to the 14 day maximum. Enter the actual COVERED dates of service as the FROM and THROUGH dates.

The "FROM" date is the date of the admission, if the recipient was eligible for the Medicaid Program benefits on admission. If the recipient was not eligible on the date of the admission, the "FROM" date is the effective date of eligibility.

For final bills, the "THROUGH" date is the fourteenth (14th) day, or last day of stay.

Enter both "FROM" and "THROUGH" dates in MM-DD-YY format.

All regular outpatient services shall be billed utilizing the actual date of service. Recurring outpatient services (i.e., physical therapy, laboratory services, etc.) shall be billed as calendar month pure claims.

F.L.23 COVERED DAYS (Inpatient Only)

Enter the total number of COVERED days from form locator 22. Data entered in form locator 23 must agree with accommodation units in form locator 52.

F.L.24 NONCOVERED DAYS (Inpatient, Only)

Enter the number of days of care not covered by the Medicaid Program.

F.L.25 CO-INSURANCE DAYS (Medicare Crossover Claims)

Enter the number of coinsurance days billed to the Medicaid Program during this billing period. Attach Medicare documentation.

F.L.26 LIFETIME RESERVE DAYS (Medicare Crossover Claims)

Enter the Lifetime Reserve days the patient has elected to use for this billing period. Attach Medicare documentation.

F.L.28 OCCURRENCE CODES AND DATES

Enter the code(s) and associated date(s) defining a significant event(s) relating to this bill. Refer to UB-82 Training Manual for codes and explanations.

F.L.40 PINTS OF BLOOD FURNISHED

Enter the total number of pints of whole blood or units of packed red cells furnished to the recipient.

F.L.41 PINTS OF BLOOD REPLACED

Enter the total number of pints of blood or units of packed red cells furnished to the recipient that have been replaced by or on behalf of the recipient.

F.L.42 PINTS OF BLOOD NOT REPLACED

Enter the total number of pints of blood or units of packed red cells that have not been replaced by or on behalf of the recipient.

F.L.43 BLOOD DEDUCTIBLE (Medicare Crossover Claims)

Enter the total number of unreplaced pints of blood or units of packed red cells furnished to the recipient that have been replaced by or on behalf of the recipient.

F.L.44 SPECIAL PROGRAM INDICATOR

Enter the code indicating that the services included on this bill are related to a special program. Refer to the UB-82 Training Manual for detailed codes and explanations.

F.L.45 KENPAC PROVIDER NUMBER (KenPAC Recipients Only)

Enter the 8-digit Kentucky Medicaid provider number of the recipient's KenPAC Primary Physician or Clinic on the upper line in this area.

F.L.50 REVENUE DESCRIPTION

Enter the narrative description of the related room, board and ancillary categories included on the bill. Enter the appropriate CPT-4 codes for outpatient or non-patient laboratory services for Revenue Codes 30X and 31X.

NOTE:

CLAIMS WITH A DATE OF SERVICE PRIOR TO DECEMBER 1, 1987, REQUIRE 1985 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER DECEMBER 1, 1987, THROUGH APRIL 30, 1988, REQUIRE 1987 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER MAY 1, 1988 THROUGH MARCH 31, 1989, REQUIRE 1988 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1989 THROUGH MARCH 31, 1990, REQUIRE 1989 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1990, THROUGH MARCH 31, 1991, REQUIRE 1990 CPT-4 CODES.

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1991, THROUGH JANUARY 14, 1992, REQUIRE 1991 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER JANUARY 15, 1992 REQUIRE 1992 CPT-4 CODES.

F.L.51 REVENUE CODES

Enter the 3-digit code identifying specific accommodation and ancillary services. A list of the Revenue codes accepted by Kentucky Medicaid can be found in Appendix XIX.

NOTE: Revenue code 001 shall always be the final entry in this column.

F.L.52 UNITS OF SERVICE

Enter the quantitative measure of services provided per revenue code to the recipient to include such items as numbers of accommodation days, pints of blood, treatments, etc.

F.L.53 TOTAL CHARGES

Enter the total charges pertaining to the related Revenue codes for the billing period.

The detailed amounts, by Revenue codes, shall equal the entry "Total Charges."

F.L.54 NON-COVERED CHARGES

Enter the charges from form locator 53 that are non-payable items by Kentucky Medicaid.

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*Form locators 57-70 are divided into 3 lines to          *
*accommodate the primary, secondary, and tertiary payers *
*Payment information shall be indicated on the            *
*corresponding line of the appropriate payer in the       *
*correct form locators 57-64.  Enter the Insured's Name   *
*in form locator 65 A, B, and C, respectively             *
```

F.L.57 PAYER IDENTIFICATION

Enter the name of payer organization from which the provider expects payment.

All other liable payers, including Medicare, shall be billed first; after settlement has been made with these payers, Medicaid can be billed for any payable balance. The Medicaid Program is payer of last resort and shall be identified as Kentucky Medicaid or KY Medicaid.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.60 DEDUCTIBLE (Medicare Crossover Claims)

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

F.L.61 CO-INSURANCE (Medicare Crossover Claims)

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

F.L.63 PRIOR PAYMENTS

Enter the amount the facility has received toward payment of the account prior to the billing date. Spend-down amount and third party payment shall be entered in this area.

NOTE: Effective for claims from Kentucky hospitals RECEIVED MARCH 1, 1987, and after, do not enter the inpatient charges being billed to Medicare Part B in Form Locator #63 of the UB-82 claim form, type of bill 111. This does not apply to out-of-state hospitals which participate in the Medicaid Program.

F.L.65 INSURED'S NAME

Enter the recipient's name in last name and first name sequence as it appears on his or her current Medical Assistance Identification Card.

F.L.68 IDENTIFICATION NUMBER

Enter the 10 digit MAID number as it appears on his or her current Medical Assistance Identification Card. [~~Exception:----MAID--numbers--of--refugee--recipients--will include-alpha-characters.~~]

F.L.77 PRINCIPAL DIAGNOSIS CODE

Enter the ICD-9-CM, Vol. 1 & 2 code describing the principal diagnosis at the time of admission.

F.L.78-81 OTHER DIAGNOSIS CODES

Enter the ICD-9-CM, Vol. 1 & 2 diagnosis codes corresponding to additional conditions that co-exist at the time of admission.

F.L.84 PRINCIPAL PROCEDURE CODE

Enter the ICD-9-CM (Vol. 3) code that identifies the principal obstetrical or surgical procedure performed during the period covered by the bill and the date on which the procedure was performed.

F.L.85 OTHER PROCEDURES CODE(S) AND DATE(S)

Enter the codes identifying the procedures, other than the principal procedure, performed during the billing period covered by this bill and the date on which the procedures were performed.

F.L.87 PRO/UR INDICATOR

Enter the indicator describing the determination arrived at by the PRO/Utilization Review Committee.

Indicator 1 = Approved as Billed
2 = Automatic Approval as Billed Based on Focus Review
3 = Partial Approval*

*If PRO/UR grants partial approval for a portion of the recipient's hospital stay, the approved dates shall be indicated in form locators 88 and 89. These dates shall agree with the dates in form locator 22.

F.L.92 ATTENDING PHYSICIAN

Enter the six-digit Unique Physician Identification Number (UPIN) and name [~~state, name and license number~~] of the attending physician.

F.L.93 OTHER PHYSICIAN ID

Enter the name and license number of physician other than attending physician.

F.L.95 PROVIDER REPRESENTATIVE SIGNATURE

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

F.L.96 DATE BILL SUBMITTED

Enter the date in month, day, year sequence in numeric format that the UB-82 form was completed and signed.

SECTION VII - COMPLETION OF INVOICE FORM

UB-82 BILLING INSTRUCTIONS
Disproportionate Share Hospitals Covering Services Provided
July 1, 1989 through June 30, 1990

1. Charges for newborns shall be submitted under the mother's name and Medical Assistance identification number (MAID#) until the date of the mother's discharge. The mother's date of discharge is the "From" date in Form Locator 22 on the initial claim for the infant.

2. Only services provided during medically necessary admissions, as determined by the PRO, are billable. Out-of-state hospitals shall perform utilization review in accordance with standards set by their state's Medicaid agency.

3. Although the date of discharge and the first birthday are non-covered days, ancillary charges incurred on the date of discharge or first birthday are covered.

4. Claims for these services shall[~~must~~] be calendar month pure, e.g. July 1, 1989 through July 31, 1989, August 1, 1989, through August 31, 1989.

5. All Kentucky Medicaid recipients are eligible for a maximum of fourteen (14) days of medically necessary inpatient hospital services per admission; therefore, when a recipient in a disproportionate share hospital reaches age one (1) and the CURRENT admission is less than fourteen (14) days in length, the balance of the admission (first birthday through the 14th day) shall be billed on a separate UB-82 claim form which will be reimbursed at the hospital's regular Medicaid per diem rate. Charges incurred on the first birthday must be included ONLY on the claim which will be reimbursed at the hospital's regular Kentucky Medicaid per diem rate.

6. When a recipient in a disproportionate share hospital reaches age one (1) and the CURRENT admission is equal to, or greater than, fourteen (14) days in length, the first birthday becomes the "THROUGH" date in Form Locator 22 and additional days cannot be billed to Medicaid for the admission.

BILLING EXAMPLES FOR DISPROPORTIONATE SHARE HOSPITALS
Services Provided July 1, 1989, through June 30, 1990

A. The infant's date of birth is 08/20/88; admitted to a disproportionate share hospital on 07/06/89, discharged 09/02/89, the billings would be as follows:

First Bill: DOA 07/06/89, TOB 112, Patient Status 30, Statement Covers Period 07/06/89-07/31/89, 26 covered days to be paid at the disproportionate share hospital rate.

Second Bill: DOA 07/06/89, TOB 114, Patient Status 01, Statement Covers Period 08/01/89-08/20/89, 19 covered days to be paid at at the disproportionate share hospital rate. Enter code 42 and 09/02/89 in form locator 28. The infant's first birthday is non-covered, and therefore considered the date of discharge for billing purposes.

B. The infant's date of birth is 08/20/88; admitted to a disproportionate share hospital on 08/10/89, discharged 09/02/90, and readmitted 09/29/89, the billings would be as follows:

First Bill: DOA 08/10/89, TOB 111, Patient Status 01, Statement Covers Period 08/10/89-08/20/89, 10 covered days to be paid at the disproportionate share hospital rate.

Second Bill: DOA 08/10/89, TOB 111, Patient Status 01, Statement Covers Period 08/20/89-08/24/89, 4 covered days to be paid at the regular hospital per diem. Enter code 42 and 09/02/89 in form locator 28 as the actual date of discharge.

Third Bill: DOA 09/29/89, TOB 111, Patient Status 01, Statement Covers Period 09/29/89-10/13/89, 14 covered days to be paid at the regular hospital per diem rate with appropriate justification attached to indicate reason for readmission within 30 days of previous discharge.

C. The infant's date of birth is 07/05/89, the mother is discharged from the hospital on 07/10/89, and the infant remains hospitalized until 12/20/89, the billings would be as follows:

First Bill: DOA 07/05/89, TOB 110, Patient Status 01, Statement Covers Period 07/05/89-07/10/89, 5 covered days. This bill is submitted under the mother's MAID number. This bill is a zero payment bill for in-state hospitals. All out-of-state hospitals shall bill this service using TOB 111 because services are paid at a percentage of usual and customary charges without year-end cost adjustment.

Second Bill: DOA 07/05/89, TOB 112, Patient Status 30, Statement Covers Period 07/10/89-07/31/89, 22 covered days to be paid at the disproportionate share hospital rate.

Third Bill: DOA 07/05/89, TOB 113, Patient Status 30, Statement Covers Period 08/01/89-08/31/89, 31 covered days to be paid at disproportionate share hospital rate.

Interim billings shall be submitted until the infant is discharged from the facility or until the infant's first birthday. Bills shall be submitted for one calendar month per UB-82.

Final Bill: DOA 07/05/89, TOB 114, Patient Status 01, Statement Covers Period 12/01/89-12/20/89, 19 covered days to be paid at disproportionate share hospital rate.

SECTION VII - COMPLETION OF INVOICE FORM

UB-82 Billing Instructions
Disproportionate Share Hospitals Covering Services Provided
On and After July 1, 1990

1. Services provided July 1, 1990 through June 30, 1991, to recipients under age one in hospitals designated as disproportionate share hospitals by Kentucky Medicaid shall be reimbursed at the regular Medicaid rate for the first thirty (30) days of the admission. Beginning on the thirty-first (31st) day of the admission, the disproportionate share rate becomes effective.

2. For newborns, the date of admission is the date of the mother's discharge on all claims for services provided on and after the mother's discharge. Because the rate change is enacted in relation to the admission date, it is critical that the admission date be correct and constant on all claims.

3. Transfers between hospitals for individuals under age one (1)shall constitute new admissions and the receiving hospital shall receive its regular Kentucky Medicaid rate for the first thirty (30) days of the admission.

4. When Kentucky Medicaid payment for an admission will include the disproportionate rate, i.e. the admission surpasses thirty days, separate UB-82 claim forms must be submitted to coincide with the appropriate rates. In addition, you are reminded that these claims shall be calendar month pure.

5. Effective for services provided on and after July 1, 1991, by hospitals designated by the Kentucky Medicaid Program as disproportionate share hospitals, recipients under age six (6) are eligible for medically necessary inpatient services without durational limits, regardless of any prior utilization of hospital services.

6. Effective for services provided on and after July 1, 1991, the Kentucky Medicaid Program will provide reimbursement for medically necessary inpatient services, without durational limits, regardless of any prior utilization of hospital services, for recipients under age one (1). Reimbursement is available as described above irrespective of designation as a disproportionate share hospital.

BILLING EXAMPLES FOR DISPROPORTIONATE SHARE HOSPITALS
Services provided on and after July 1, 1990

A. An infant is born in a disproportionate share hospital on July 15, 1990, the mother is discharged on July 18, 1990, and the infant is discharged on October 13, 1990.

	STATEMENT COVERS PERIOD	TYPE OF BILL	NUMBER OF DAYS	RATE OF REIMBURSEMENT
Claim #1	07/15/90 to 07/18/90	110*	3	Zero Pay*
Claim #2	07/18/90 to 07/31/90	112	14	Regular
Claim #3	08/01/90 to 08/16/90	113	16	Regular
Claim #4	08/17/90 to 08/31/90	113	15	Disproportionate Share
Claim #5	09/01/90 to 09/30/90	113	30	Disproportionate Share
Claim #6	10/01/90 to 10/13/90	114	12	Disproportionate Share

*Because Kentucky Medicaid does not cost settle with out-of-state hospitals, out-of-state disproportionate share hospitals shall continue to bill this claim as Type of Bill 111 and reimbursement will be the lower of the two methodologies.

B. The infant is born on July 10, 1990, is admitted to a disproportionate share hospital on August 2, 1990, becomes Kentucky Medicaid eligible on August 14, 1990, and is discharged on September 10, 1990.

	STATEMENT COVERS PERIOD OF PERIOD	TYPE OF BILL	NUMBER OF DAYS	RATE OF REIMBURSEMENT
Claim #1	08/14/90 to 08/31/90	112	18	Regular
Claim #2	09/01/90 to 09/10/90	114	9	Disproportionate Share

G. HCFA-1500 (12/90) Billing Instructions

The Medicare Part B cross-over claims covering hospital-based physician services (i.e., emergency room physician, anesthesiologist, cardiologist, etc.) are transmitted to the Kentucky Medicaid Program by Blue Cross/Blue Shield, Lexington, Kentucky via tape. If a claim, covering the Part B deductible or coinsurance amount, does not appear on the Medicaid Remittance Statement within thirty (30) days of the Medicare adjudication date, a paper HCFA-1500 (Rev. 12/90) with the corresponding Explanation of Benefits shall be submitted to Kentucky Medicaid utilizing the billing instructions listed below.

Note: Only those fields required for billing Kentucky Medicaid are completed. Specific billing requirements are indicated within the claim form field description.

Field Description

1 INSURANCE IDENTIFICATION INDICATOR

Check the "Medicare" and "Medicaid" blocks when billing a claim to Medicare requesting Medicare to send the claim to Medicaid for processing coinsurance and deductible amounts.

1A INSURED'S I.D. NUMBER

Required only if billing Kentucky Medicaid for coinsurance and deductible (Medicare\Medicaid crossover claims). Enter the recipient's Medicare identification number.

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

Enter the recipient's last name, first name, middle initial exactly as it appears on the Medical Assistance Identification (MAID) Card.

SECTION VII - COMPLETION OF INVOICE FORM

9A OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the recipient's ten-digit Medical Assistance Identification Number (MAID) exactly as it appears on the recipient's MAID card.

10 PATIENT'S CONDITION

Required if recipient's condition is related to employment, auto accident, or other accident. Check the appropriate "yes" block if recipient's condition relates to one of the above; otherwise, leave blank.

11 INSURED'S POLICY GROUP OR FECA NUMBER

Required if recipient has another insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the policy number of the other insurance.

11C INSURANCE PLAN NAME OR PROGRAM NAME

Required if recipient has another insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the name of the other insurance company.

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Complete if recipient was referred from another provider to the billing provider for consultation procedures. Enter the name of the referring provider, if applicable.

17a I.D. NUMBER OF REFERRING PHYSICIAN

Enter the six-digit Unique Physician Identification Number (UPIN) of the referring physician, if applicable.

19 RESERVED FOR LOCAL USE

Required for KenPac and Lock-In recipients who are referred for treatment. Enter the eight-digit Medicaid provider number of referring KenPac or Lock-In provider.

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Enter the appropriate ICD-9-CM diagnosis code as the diagnosis code appears in the ICD-9-CM International Classification of Disease Book. You may enter up to three diagnosis codes.

24A DATE(S) OF SERVICE

Enter the date(s) the service was provided in month, day, year sequence and in numeric format; for example 03/02/92.

24B PLACE OF SERVICES

Enter the appropriate two-digit place of service code which identifies the location where the service was provided to the recipient. The correct code for inpatient hospital services is 21 and outpatient hospital services is 22.

24D PROCEDURES, SERVICES, OR SUPPLIES

CPT/HCPCS

Enter the appropriate procedure code identifying the service or supply provided to the recipient.

24E DIAGNOSIS CODE

Enter "1", "2", "3" referencing the diagnosis for which the recipient is being treated as indicated in field 21.

24F CHARGES

Enter the usual and customary charge for the service being provided to the recipient.

26 PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key up to seven (7) alpha/numeric characters. This number appears on the Medicaid remittance statement as the invoice number.

SECTION VII - COMPLETION OF INVOICE FORM

28 TOTAL CHARGE

Enter the total of all individual charges entered in column 24F. Total each claim separately.

29 AMOUNT PAID

Enter the amount paid, if any, by a private insurance. DO NOT ENTER MEDICARE PAID AMOUNT.

30 BALANCE DUE

REQUIRED ONLY IF A PRIVATE INSURANCE MADE PAYMENT ON THE CLAIM. Subtract the private insurance payment entered in field 29 from the total charge entered in field 28, and enter the net balance due in field 30.

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

A handwritten signature is required. A delegated signature such as an authorized representative of the provider is acceptable. Stamped signatures, however, are not acceptable.

DATE

Enter the date in a month, day, year sequence and in numeric format. This date must be on or after the date(s) of service billed on the claim. For example, enter the date as 04/18/92.

33 PHYSICIAN'S SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE, AND PHONE NUMBER

Enter the provider's name, address, zip code and telephone number.

PIN#

Enter the eight-digit individual Kentucky Medicaid hospital provider number.

TYPE OF INFORMATION REQUESTED	NECESSARY INFORMATION
Refund	1. Cash Refund Documentation 2. Refund Check 3. Photocopy of the applicable portion of the Remittance Statement in question

B. Telephone Inquiry Information

WHAT IS NEEDED?

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

WHEN TO CALL?

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

WHERE TO CALL?

-Toll-free number 1-800-756-7557 [~~333-2188~~] (within Kentucky)
-Local (502) 227-2525

C. Filing Limitations

NEW CLAIMS - 12 months from date of service

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-756-7557 [~~333-2188~~] or 1-(502)-227-2525.

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

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

Provider Inquiry forms shall NOT be used in lieu of the Medicaid Program claim forms, Adjustment forms, or any other document required by the Medicaid Program.

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

Instructions for completing the Provider Inquiry form are found below.

FIELD NUMBER	INSTRUCTIONS
1	Enter the 8-digit Kentucky Medicaid Provider Number.
2	Enter the Provider Name and Address.
3	Enter the Medicaid recipient's name as it appears on the Medical Assistance Identification [~~I.D.~~] Card.
4	Enter the recipient's 10 digit Medical Assistance Identification [~~I.D.~~] number.
5	Enter the billed amount of the claim on which you are inquiring.

To reorder these inquiry forms contact the Communications Unit by mail:

EDS
P.O. Box 2009
Frankfort, KY 40602

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

F. Cash Refund Documentation Form

The Cash Refund Documentation form shall be completed when a provider sends a refund check. The completed form and a copy of the remittance statement page showing the paid claim being refunded shall accompany the check. Please mail to the following address:

EDS
P.O. Box 2009
Attn: Financial Services
Frankfort, KY 40602

If a check is sent without the Cash Refund Documentation form, the check will not be posted to a specific claim. This[~~Such~~] action would not reflect the refund being made for a particular claim, possibly leaving the provider responsible for another refund at a later date. If there are any questions concerning the form, please call the Provider Relations Unit at 1-800-756-7557[~~333-2188~~] or 1-(502)-227-2525.

FIELD NUMBER	DESCRIPTION
1	Enter the check number
2	Enter the amount of the check
3	Enter the provider name, provider number and address
4	Enter the name of recipient on claim being refunded
5	Enter the recipient's Medicaid identification number (10 numeric digits)

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 [~~a~~] durable medical equipment, [~~supplier or supplier of~~] orthotics and prosthetics. Most items require prior authorization.

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.

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.

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.

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 facilties 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.

[~~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.~~]

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.

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.

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.

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).

DEPARTMENT FOR MEDICAID SERVICES

[~~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.

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/DD).~~]

~~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.

[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.]