

**KENTUCKY MEDICAL ASSISTANCE PROGRAM
HOSPICE PROGRAM MANUAL
POLICIES AND PROCEDURES**

**Cabinet for Human Resources
Department for Medicaid Services
Frankfort, Kentucky 40621**

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SECTION I - INTRODUCTION

I. INTRODUCTION

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

This manual is intended to provide basic information concerning coverage, billing, and policy. It will, hopefully, assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Policy and Provider Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 333-2188 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

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

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

II. KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

A. General

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

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

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

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

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

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

B. Administrative Structure

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

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

C. Advisory Council

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

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

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

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

D. Policy

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

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

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

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

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

Each medical professional is given the choice of whether or not to participate in the Kentucky Medical Assistance Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his or her medical care.

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

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

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

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

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

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

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

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his or her suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he or she receives.

No claim may be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims will be paid for services that required, but did not have, prior authorization by the Kentucky Medical Assistance Program.

No claims may be paid for medically unnecessary items, services, or supplies.

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

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

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

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

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

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

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

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

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

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

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

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

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

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

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

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

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

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

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

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

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

(d) Whoever knowingly and willfully--

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

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

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

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

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

F. Timely Submission of Claims

In order to receive Federal Financial Participation, claims for covered services rendered eligible Title XIX recipients must be received by the Department for Medicaid Services within twelve (12) months from the date of service. Claims received after that date will not be payable. This policy became effective August 23, 1979.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

G. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medical Assistance Program (KMAP), provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; skilled nursing facility (SNF), intermediate care facility (ICF), and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular KMAP recipients, the KenPAC recipients will have a color-coded KMAP card with the name, address, and telephone number of their primary care provider.

The primary care physician is listed on the green KenPAC medical card. The Hospice Program is not currently affected by KenPAC.

SECTION III - DEVELOPMENT OF HOSPICE SERVICES

III. DEVELOPMENT OF HOSPICE SERVICES

Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272)

On April 7, 1986, the President signed into law H.R. 3128, The Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA). The provisions of Section 9505 of this act allowed states to include under their State Plan for Medical Assistance, hospice benefits for terminally ill recipients who elect to receive it.

The law specifies that states must require participating providers of Hospice services to meet the same requirements for organization and operation as are required under Medicare. Reimbursement for covered services must also follow Medicare's reimbursement methodology.

The Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, will implement the hospice benefit, effective 10/01/86.

SECTION IV - CONDITIONS OF PARTICIPATION

IV. CONDITIONS OF PARTICIPATION

A. Provider Participation Requirements

In order to be eligible to participate in the Kentucky Medical Assistance Program as a provider of Hospice services, the Hospice must first be licensed by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board to provide hospice services in accordance with the requirements set forth in 902 KAR 20:140, and be certified by Title XVIII, Medicare, as a provider of hospice services. Further, the hospice must meet any additional certification requirements of the Title XIX program as outlined in 907 KAR 1:330 in the provision of covered hospice services required to meet the needs of the client. These services may be provided directly or through written contractual arrangements with another individual or entity for which the participating provider will be held responsible.

B. Application for Participation

An application for participation in the Title XIX Hospice Program element shall consist of the following:

- 1) Participation Agreement (MAP-343)
- 2) Provider Information Form (MAP-344)
- 3) Copy of Medicare form listing Medicare payment rates
- 4) Copy of Medicare Certification Letter
- 5) Copy of Certificate of Need

Copies of the Participation Agreement and Provider Information Form may be found in Appendix III and IV of this manual.

The completed Application for Participation should be sent to the following address:

Cabinet for Human Resources
Department for Medicaid Services
Provider Enrollment
275 East Main Street
Frankfort, KY 40621

Approval of an Application for Participation will include a signed copy of the Agreement and notification of the billing provider number.

SECTION IV - CONDITIONS OF PARTICIPATION

C. Change in Service Area

If there is a change in the provider's service area (adding or deleting a county or counties to be served) a copy of the new Certificate of Need identifying that change must be sent to the Department for Medicaid Services as soon as it is received by the provider so that the local Department for Social Insurance Offices can be notified that the provider is now available or unavailable in that county.

D. Licensure

Employees who provide hospice services must be licensed, certified or registered in accordance with applicable Federal or state laws.

E. Medical Director

The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

F. Continuation of Care

A hospice may not discontinue or diminish care provided to a Medicaid beneficiary because of the beneficiary's inability to pay for that care.

G. Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or the individual's representative.

SECTION IV - CONDITIONS OF PARTICIPATION

H. Interdisciplinary Group

1. The hospice must designate an interdisciplinary group or groups composed of the following individuals who are employees of the Hospice and who provide or supervise the care and services offered by the hospice.
 - a. a doctor of medicine or osteopathy
 - b. a registered nurse
 - c. a social worker
 - d. a pastoral or other counselor
2. The interdisciplinary group is responsible for the following:
 - a. participation in the establishment of the plan of care
 - b. provision or supervision of hospice care and services
 - c. periodic review and updating of the plan of care for each individual receiving hospice care
 - d. establishment of policies governing the day-to-day provision of hospice care and services.
3. If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described above.
4. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

I. Plan of Care

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

1. The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

SECTION IV - CONDITIONS OF PARTICIPATION

2. The plan must be reviewed and updated at intervals specified in the plan by the attending physician, the medical director, or physician designee and interdisciplinary group. These reviews must be documented.
3. The plan must include the assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

J. Medical Records

1. Medical records must substantiate the services billed to the KMAP by the hospice. The medical records must be accurate and appropriate and must include the following:
 - a. the initial and subsequent assessments
 - b. the plan of care
 - c. identification data
 - d. consent and authorization and election forms
 - e. pertinent medical history
 - f. complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)
2. All records must be signed by the staff person providing the service and dated.
3. Medical records must be maintained for a minimum of five years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments claimed must be maintained in an organized central file and furnished to employees of the Cabinet for Human Resources or Federal Government upon request, and made available for inspection and/or copying by Cabinet personnel.

SECTION IV - CONDITIONS OF PARTICIPATION

K. Termination of Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;
2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;
3. Misrepresenting factors concerning a facility's qualifications as a provider;
4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or
5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least fifteen (15) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;
2. The effective date;
3. The extent of its applicability to participation in the Medical Assistance Program;
4. The earliest date on which the Cabinet will accept a request for reinstatement;

SECTION IV - CONDITIONS OF PARTICIPATION

5. The requirements and procedures for reinstatement; and
6. The appeal rights available to the excluded party.

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

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

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;
2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;
3. Counsel representing the provider;
4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and
5. An opportunity to cross-examine witnesses.

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

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

SECTION IV - CONDITIONS OF PARTICIPATION

L. Annual Recertification

In accordance with Federal requirements, a hospice provider's certification and participation with the KMAP must run concurrently with the provider's license issued by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board. Since hospice agencies are re-licensed annually, it will be necessary for hospice providers to be recertified with the KMAP on an annual basis.

If for any reason a hospice provider's license is not renewed, that provider's participation with the KMAP will be terminated and no payment will be made to the provider for services rendered after the expiration date of the previous year's license until such time as notification of relicensure is received by the KMAP.

Upon receipt of notification of relicensure, the provider will be recertified with the KMAP for the entire period of time covered by the new license.

SECTION V - ELIGIBILITY REQUIREMENTS

V. ELIGIBILITY REQUIREMENTS

In order to be eligible to elect hospice care as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as being terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. Additionally, those medically indigent persons who are terminally ill and who would be Medicaid eligible if institutionalized may also qualify for hospice benefits.

A. Application for Medicaid Benefits

The medically-indigent individual who is not currently a Medicaid recipient, but who has been certified as being terminally ill and has requested the hospice service, may apply for Medical Assistance benefits at the local office of the Department for Social Insurance in the individual's county of residence. An interested party may apply on behalf of the individual.

A completed and signed copy of the Election of Medicaid Hospice Benefits form, MAP-374, will need to be presented to the local office at the time of application.

B. Duration of Benefits

Effective 1/01/89, there is no limit on the number of days a patient may receive hospice care.

C. Certification of Terminal Illness

The hospice must obtain the certification that an individual is terminally ill in accordance with the following requirements:

1. The hospice must obtain, no later than 2 calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician.

SECTION V - ELIGIBILITY REQUIREMENTS

2. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s) required to certify the terminal illness. The hospice maintains the certification statements.
3. An individual who is eligible for Medicare hospice benefits must elect to use the Medicare benefits as the primary source of payment. The date Medicare eligibility begins must be entered on the Election of Medicaid Hospice Benefits Form (MAP-374). The KMAP may make co-payments for drugs and/or respite care.
4. For an individual who is eligible for both Medicare and Medicaid benefits and who resides in a long term care facility, room and board charges may be paid by Medicaid.

D. Election of Hospice Care

1. If an individual who meets eligibility requirements for hospice care elects to receive that care, an Election of Benefits Form (MAP-374) must be completed by the individual or the individual's representative who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.
2. An election to receive Medicaid hospice care will be considered to continue indefinitely without a break in care, as long as the individual remains in the care of the hospice and does not revoke the election in writing. (Revocation of Medicaid Hospice Benefits Form, MAP-375)
3. The individual or representative may designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual may not designate an effective date that is earlier than the date that the election is made.

SECTION V - ELIGIBILITY REQUIREMENTS

4. An individual waives all rights to Medicaid benefits for the duration of the election of hospice care for the following services:
 - a. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided by arrangements made by the designated hospice).
 - b. Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected except for services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.
5. The election statement includes the following:
 - a. identification of the particular hospice that will provide care to the individual
 - b. the individual's (or representative) acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to his or her terminal illness
 - c. acknowledgement that certain Medicaid services are waived by the election of hospice care
 - d. the effective date of the election
 - e. the signature of the individual or representative.
6. A copy of the election form for all clients who elect hospice coverage must be forwarded to the Department for Medicaid Services and to the local Department for Social Insurance Office.

SECTION V - ELIGIBILITY REQUIREMENTS

E. Revoking Election of Hospice Care

An individual (or representative) may revoke the election of hospice care at any time during the benefit period.

1. To revoke the election of hospice care, the individual (or representative) must complete the Revocation of Hospice Benefit, form MAP-375, and file with the hospice. A copy of this form must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance Office.
2. Upon revocation of the election of Medicaid coverage of hospice care, the individual is no longer covered by Medicaid for hospice care, but if eligible, may resume Medicaid coverage under the regular scope of benefits. The individual may at any time elect to receive hospice coverage for any other benefit periods he or she is still eligible to receive.

F. Change of the Designated Hospice

An individual (or representative) may change the designation of the particular hospice from which the hospice care will be received once.

1. The change of the designated hospice is not a revocation.
2. To change the designated hospice provider, the individual (or representative) must complete form MAP-376, Change of Hospice Providers, and file with the hospice from which care has been received and with the newly designated hospice.

A copy must also be forwarded to the Department for Medicaid Services and to the local Department for Social Insurance Office.

G. Inactive Status

A lapse in the hospice benefit is allowed if the patient's condition improves to an extent that active hospice services are temporarily unnecessary. If the patient's condition has improved, the patient may be placed in inactive status by the hospice agency until the patient's condition once again requires active hospice services.

SECTION V - ELIGIBILITY REQUIREMENTS

No hospice services (including room and board or bed reservation days) may be billed for any patient in inactive status. The patient may revert to regular Medicaid benefits; however, since Medicaid eligibility for hospice patients is determined using a special income standard, some patients may not be eligible for Medicaid benefits during inactive status.

The Termination of Medicaid Hospice Benefits Form (MAP-378) or the Hospice Patient Status Change Form (MAP-403) must be used to notify the Department for Medicaid Services that the patient is entering inactive status.

When the patient returns to active status, a Hospice Patient Status Change Form (MAP-403) must be completed indicating the date that the patient will be in active status and must be sent to the Department of Medicaid Services and the local Department for Social Insurance Office and the patient will be again added to the hospice file.

H. Termination of Hospice Care

1. Notification of Death

The hospice agency is required to notify the Department for Medicaid Services of the death of a recipient no later than two (2) days following the death. Additionally a Termination of Medicaid Hospice Benefits Form (MAP-378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance office.

2. Inactive Status

The hospice agency is required to notify the Department for Medicaid Services within two working days if the patient goes into inactive status using the Termination of Medicaid Benefits Form (MAP-378) or the Hospice Patient Status Change Form (MAP-403).

SECTION V - ELIGIBILITY REQUIREMENTS

H. Extension of Hospice Care Beyond Three Benefit Periods

At the end of the final 30-day benefit period, the KMAP will consider an extension of the hospice care benefits for up to sixty consecutive (60) days. The extension is to be requested by submission of the form, MAP-377, Request for Extension of Medicaid Hospice Benefits. This form requires a statement from the Hospice Medical Director that the patient's life expectancy is 60 days or less. Patients who have been in inactive status are also eligible for the 60 day extension and that period may be saved for as long as necessary.

The request for extension must be received by the Department for Medicaid Services, five days prior to the end of the 30 day benefit period.

I. Termination of Hospice Care

1. If hospice care is terminated because covered days have been exhausted, a Termination of Medicaid Hospice Benefits form (MAP-378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance Office.

2. Notification of Death

The hospice agency is required to notify the Department for Medicaid Services of the death of a recipient no later than two (2) days following the death. Additionally a Termination of Medicaid Hospice Benefits Form (MAP-378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance office.

3. Inactive Status

The hospice agency is required to notify the Department for Medicaid Services within two working days if the patient goes into inactive status using the Termination of Medicaid Benefits Form (MAP-378). The date the patient became inactive must be entered and the section marked "Other" must be completed indicating "inactive" status.

SECTION VI - COVERED SERVICES

VI. COVERED SERVICES

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The individual, having been certified as being terminally ill, must elect hospice coverage. A plan of care must be established and the services must be consistent with the plan of care.

A. General Coverage

The Medicare Guidelines have been followed in the development of the Medicaid Hospice Scope of Benefits. The following services are covered:

1. Core Services

A hospice must ensure that substantially all the core services are routinely provided directly by hospice employees. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet all requirements.

2. Nursing Services

The hospice must provide nursing care and services by or under the supervision of a registered nurse.

- a. Nursing services must be directed and staffed to assure that the nursing needs of patients are met.
- b. Patient care responsibilities of nursing personnel must be specified.
- c. Services must be provided in accordance with recognized standards of practice.

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3. Counseling Services

Counseling services must be available to both the individual and the family. Counseling includes bereavement counseling provided after the patient's death, as well as dietary, spiritual, and any other counseling services for the individual and family provided while the individual is enrolled in the hospice.

- a. There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient).
- b. Dietary counseling, when required, must be provided by a qualified individual.
- c. Spiritual counseling must include notice to patient as to the availability of clergy.
- d. Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

4. Physical Therapy, Occupational Therapy, and Speech-Language Pathology

Physical therapy, occupational therapy services and speech-language pathology services must be available and, when provided, offered in a manner consistent with accepted standards of practice.

SECTION VI - COVERED SERVICES

5. Home Health Aide and Homemaker Services

Home Health aide and homemaker services must be available and adequate in frequency to meet the needs of the patients.

- a. A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services.
- b. Written instructions for patient care are prepared by a registered nurse. Duties include but may not be limited to the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.

6. Medical Supplies

Medical supplies and appliances, including drugs and biologicals must be provided as needed for the palliation and management of the terminal illness and related conditions.

- a. All drugs and biologicals must be administered in accordance with accepted standards of practice.
- b. The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient.
- c. Drugs and biologicals are administered only by the following individuals.
 - (1) a licensed nurse or physician
 - (2) an employee who has completed a state-approved training program in medication administration

SECTION VI - COVERED SERVICES

- (3) the patient if his or her attending physician has approved
- (4) any other individual in accordance with applicable state and local laws; the persons and each drug and biological they are authorized to administer must be specified in the patient's plan of care.

7. Short Term Inpatient Care

Inpatient care must be available for pain control, symptom management and respite purposes and must be provided in a participating Medicare or Medicaid facility.

- a. Inpatient care for pain control and symptom management must be provided in a hospital or an SNF that also meets standards for direct inpatient care, and 24 hour nursing service.
- b. Inpatient care for respite purposes must be provided by a hospital or an SNF that also meets the standards for direct inpatient care and 24 hour nursing service or an ICF that meets those same standards.

8. Medical Social Services

Medical social services must be provided by a qualified social worker, under the direction of a physician.

B. Special Coverage Requirements

When necessary, special coverage of some services will be available during period of crisis or for respite care.

1. Periods of Crisis

During periods of crisis, nursing care may be covered on a continuous basis for as much as 24 hours a day as necessary to maintain the individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous

SECTION VI - COVERED SERVICES

basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

2. Inpatient Respite Care

Respite Care is short-term inpatient care provided in a participating hospital, skilled nursing facility or intermediate care facility to the individual only when necessary to relieve the family members or other persons caring for the individual. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days.

3. Bereavement counseling is a required hospice service but is not directly reimbursable.

C. Physician Services

Physician services will not be covered as a separate service through the Hospice program but will continue to be payable through the physician element of the KMAP when billed by the physician in the usual manner.

D. Hospital Services

Inpatient hospitalization for illnesses or conditions not related to the patient's terminal illness will not be covered through the hospice program but will continue to be payable through the hospital element of the KMAP when billed by the hospital in the usual manner.

The Hospice should submit to the hospital an Other Hospitalization Statement (MAP-383) signed by the hospice medical director which says that it has been determined by the hospice that this illness/accident is not related to the terminal illness of the patient. A copy of the MAP-383 should be retained by the hospice agency.

SECTION VI - COVERED SERVICES

E. Pharmacy

Drugs related to the terminal illness of the patient will be covered by the hospice program and included in the per diem rate.

For those drugs not related to the terminal illness of the patient, the hospice agency should complete a Hospice Drug Form (MAP-384) and submit both copies along with the Election of Benefits Form (MAP-374). The KMAP will return one copy to the hospice agency indicating the allowable maximum Medicaid payment for each drug. The hospice agency will bill the actual cost, up to the Medicaid maximums, for those drugs on the UB 82 billing form, using the revenue code 250 (General Classification). Payment will be made to the hospice for those drugs at 100% of the billed charge, up to the Medicaid maximum. The MAP-384 need be submitted only one time at the time of election of hospice coverage unless the prescriptions are changed or unless hospice coverage is revoked. If hospice coverage is revoked and then reinstated, a new MAP-384 should be submitted with the Election of Benefits form.

F. Room and Board

Room and board for hospice clients residing in a long term care facility which participates with Medicare will be covered by the hospice program and payment for room and board will be made in addition to the payment for routine hospice care and continuous care services. In this type of situation, the hospice agency is responsible for the professional management of the individual's hospice care and the long term care facility agrees to provide room and board. Medicaid payment will be made to the hospice agency and the hospice agency will make payment to the long term care facility.

In the case of continuous nursing care for clients residing in long term care facilities, all requirements for continuous nursing care in the home must be met; it will be the responsibility of the hospice agency to go into the long term care facility and provide continuous care for as long as necessary.

SECTION VI - COVERED SERVICES

In order to assure appropriate eligibility determinations for clients residing in long term care facilities, the hospice must notify the local Department for Social Insurance whenever a client enters or leaves a long term care facility and indicate whether the facility is a skilled nursing facility or an intermediate care facility. If the patient is in a long term care facility at the time the hospice benefit is elected, the name of the facility and the type of facility (ICF or SNF) must be entered on the Election of Medicaid Benefits Form (MAP-374).

The reimbursement rate for room and board is set at 75% of the intermediate care upper limit for IC, and at 115% of the intermediate care add on for SN. When upper limits are revised for IC and SN, new room and board rates will be calculated accordingly.

Charges for room and board must be billed on the same UB-82 as the other procedures for those dates of services (i.e. routine home care or continuous nursing care) except for patients with both Medicare and Medicaid.

Charges for room and board may not be billed for patients who are in inactive status.

G. Bed Reservation Days

Bed Reservation Days for hospice clients residing in a long term care facility who require inpatient hospitalization will be covered by the hospice program in order to guarantee that the bed in the long term care facility will be available to the client upon discharge from the hospital. Payment for bed reservation days will be made to the hospice agency in addition to the payment for general inpatient care.

Reimbursement for bed reservation days will also be allowed for hospice clients residing in a long term care facility who temporarily return to a home setting for therapeutic purposes. In these instances, the hospice agency must continue to provide the patient's care and the payment for bed reservation days will be made in addition to the payment for either routine home care or continuous nursing care, whichever is appropriate.

SECTION VI - COVERED SERVICES

In both instances Medicaid payment for bed reservation days will be made to the hospice agency and the hospice agency will make payment to the long term care facility.

The reimbursement rate for bed reservation days will be the same as the rate paid for room and board when the patient is actually in the long term care facility.

Payment for bed reservation days for the purpose of inpatient hospitalization will be limited to fourteen (14) consecutive days per recipient and a total of forty-five (45) days per lifetime.

Payment for bed reservation days for the purpose of therapeutic home visits will be limited to fifteen (15) days per lifetime.

If the patient dies while in the hospital or on a home visit, the long term care facility should be notified immediately. Payment for bed reservation days will not be made for any day after the date of death.

Charges for bed reservation days must be billed on the same UB-82 as the other procedures for those dates of service (i.e. general inpatient care, routine home care, continuous nursing care) except for patients with both Medicare and Medicaid. Charges for bed reservation days may not be billed for patients in inactive status.

H. Categories of Covered Services

Hospice services are divided into five basic categories of services plus two categories for room and board and, four categories for bed reservation days. With the exception of pharmacy items not related to the terminal illness, a payment rate is established by Medicare for each category. A revenue code is assigned to each category for billing purposes.

The categories of service and the revenue codes are as follows:

- 651 Routine Home Care - routine nursing service, social work, counseling services, durable medical equipment, supplies, drugs, home health aide/homemakers, physical therapy, occupational therapy and speech and language pathology therapy.

SECTION VI - COVERED SERVICES

- 652 Continuous Home Care - in periods of acute medical crisis, 24 hour nursing care may be instituted in the home.
- 655 Respite Care - for a limited time, not to exceed five consecutive days, the patient may receive respite care in a licensed Skilled or Intermediate Care Facility, or acute care hospital.
- 656 General Inpatient - in periods of acute medical crisis, the patient may be hospitalized for palliative care.
- 653 Room and Board SNF - for hospice patients residing in a skilled nursing facility which participates with Medicare, room and board is paid in addition to the rate for routine home care and continuous home care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates (except for patients with both Medicare and Medicaid).
- 654 Room and Board ICF - for hospice patients residing in an intermediate care facility which participates with Medicare, room and board is paid in addition to the rate for routine home care and continuous home care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates (except for patients with both Medicare and Medicaid).
- 182 ICF Bed Reservation Days Home - for hospice patients residing in an intermediate care facility who return to a home setting temporarily for therapeutic purposes, bed reservation days (not to exceed 15 per lifetime) are paid in addition to the rate for routine home care or continuous nursing care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.
- 183 SNF Bed Reservation Days Home - for hospice patients residing in a skilled nursing facility who return to a home setting temporarily for therapeutic purposes, bed reservation days (not to exceed 15 per lifetime) are paid in addition to the rate for routine home care or continuous nursing care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.

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- 184 ICF Bed Reservation Days Hospital - for hospice patients residing in an intermediate care facility who require inpatient hospitalization, bed reservation days (not to exceed 14 consecutive days or 45 total days per lifetime) are paid in addition to the rate for general inpatient care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.
- 185 SNF Bed Reservation Days Hospital - for hospice patients residing in a skilled nursing facility who require inpatient hospitalization, bed reservation days (not to exceed 14 consecutive days or 45 total days per lifetime) are paid in addition to the rate for general inpatient care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.
- 250 General Classification Pharmacy - prescriptions not related to the terminal illness.

I. Other Covered Services

Services which are not covered by the hospice program but which the patient may need are payable through other elements of the KMAP in accordance with the Medicaid scope of benefits. These services may include:

Medical Transportation
Dental
Renal Dialysis
Nurse Anesthetist

J. Services Not Related to the Terminal Illness

As with inpatient hospitalization for illnesses or conditions not related to the terminal illness of the patient, certain other services which are usually covered under the hospice benefit may be considered separately and billed to the KMAP by the appropriate provider if the service is determined to be totally unrelated to the terminal illness of the patient.

SECTION VI - COVERED SERVICES

1. Durable Medical Equipment

If a patient requires durable medical equipment for a condition that is separate from and totally unrelated to the terminal illness of the patient, charges for the equipment may be billed to the KMAP by a home health agency.

2. Outpatient Hospital Services

If a patient requires outpatient hospital services for a condition that is separate from and totally unrelated to the terminal illness of the patient, charges for the services may be billed to the KMAP by the hospital. Prior approval must be obtained from the KMAP. The Other Hospitalization Statement (MAP-383) should be submitted to the KMAP for review along with documentation which includes the terminal diagnosis and present condition of the patient and verification that the reason for this hospitalization is in no way related to the terminal illness.

3. Other Services

If a patient requires other medical services for a condition that is separate from and totally unrelated to the terminal illness of the patient, charges for the services may be billed to the KMAP by the appropriate provider.

In all of the instances described above, prior approval must be obtained from the KMAP before payment can be made to providers other than the hospice agency. Prior approval may be obtained by submitting to the KMAP a completed Other Services Statement (MAP-397) along with documentation which clearly indicates that the services provided are in no way related to the terminal illness of the patient.

A copy of the form will be returned to the hospice agency indicating whether or not the request has been approved.

If approved, the hospice agency should forward the form to the provider who will be responsible for billing for the service. The hospice agency should retain a copy of the form.

SECTION VI - COVERED SERVICES

K. Nutritional Supplements

In most cases, nutritional supplements are considered part of the palliation and routine care of the hospice patient and charges for the nutritional supplements are included in the hospice agency's per diem rate. If, however, the condition of the patient is such that nutritional supplements provide the total nutrition of the patient, charges for the nutritional supplement may be billed separately and payment will be made in addition to the usual per diem rate; however, prior approval must be obtained from the KMAP. Payment will be made in accordance with the KMAP maximums allowed for nutritional supplements.

Prior approval may be obtained by submitting to the KMAP a completed Hospice Drug Form (MAP-384) along with documentation from the patient's physician which clearly indicates that the patient requires the nutritional supplement for his/her total nutrition.

If approved, the form will be returned to the hospice agency with the KMAP maximum for the nutritional supplement entered in block 12. That amount may then be billed to the KMAP on the UB-82, with or without other hospice charges, using code 250.

SECTION VII - REIMBURSEMENT

VII. REIMBURSEMENT

A. Method of Reimbursement

Hospice services are reimbursed on the basis of an established rate per unit for the covered service rendered. This rate is the same as the Medicare rate. Services must be provided in accordance with the terms and conditions described in this manual. The recipient receiving these services must be a Medicaid recipient and meet the eligibility criteria for hospice care.

B. Billing Form

The Universal Billing Form, UB-82, will be used to bill for Medicaid Hospice Services.

C. Covered Services/Revenue Codes

1. Routine Home Care

- a. Revenue Code: 651
- b. Unit of Service: 1 day (24 hours)

2. Continuous Home Care

- a. Revenue Code: 652
- b. Unit of Service: 1 hour (minimum 8 hours per 24 hour period)

3. Inpatient Respite Care

- a. Revenue Code: 655
- b. Unit of Service: 1 day (24 hours)

4. General Inpatient Care (Non-Respite)

- a. Revenue Code: 656
- b. Unit of Service: 1 day (24 hours)

SECTION VII - REIMBURSEMENT

5. Room and Board SNF
 - a. Revenue Code: 653
 - b. Unit of Service: 1 day (24 hours)
6. Room and Board ICF
 - a. Revenue Code: 654
 - b. Unit of Service: 1 day (24 hours)
7. ICF Bed Reservation Days Home
 - a. Revenue Code: 182
 - b. Unit of Service: 1 day (24 hours)
8. SNF Bed Reservation Days Home
 - a. Revenue Code: 183
 - b. Unit of Service: 1 day (24 hours)
9. ICF Bed Reservation Days Hospital
 - a. Revenue Code: 184
 - b. Unit of Service: 1 day (24 hours)
10. SNF Bed Reservation Days Hospital
 - a. Revenue Code: 185
 - b. Unit of Service: 1 day (24 hours)
11. General Classification Pharmacy (Prescriptions Not Related to Terminal Illness)
 - a. Revenue Code: 250
 - b. Unit of Service: 1 prescription = 1 unit
12. Total of All Billed Charges Revenue Code: 001

SECTION VII - REIMBURSEMENT

On any day on which the recipient is not an inpatient, the hospice is paid the routine home care rate unless the patient receives continuous care. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous care rate is divided by 24 to yield an hourly rate. The number of hours of continuous care during a continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight hours of care must be provided on a particular day to qualify for the continuous home care rate.

On any day on which the recipient is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid.

Payment for inpatient respite care may not be for more than 5 consecutive days; payment for the sixth and any subsequent days of inpatient respite care is made at the routine home rate.

If the recipient dies while an inpatient, and is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day.

For recipients residing in a skilled nursing or intermediate care facility payment for room and board for each day is made in addition to the payment for routine home or continuous home care for that day. (In the case of continuous care, the hospice agency must go into the long term care facility and provide continuous nursing care services.)

For recipients residing in a skilled nursing or intermediate care facility and who are out of the facility due to inpatient hospitalization or home visitation, payment for bed reservation days for each day the patient is out of the facility will be made in addition to the payment for routine home care, continuous nursing care or general inpatient care, whichever is applicable. (In the

SECTION VII - REIMBURSEMENT

case where the patient is away from the long term care facility for home visitation, the hospice agency must continue to provide the patient's care.) Payment for bed reservation days will be limited to a maximum of 14 consecutive days and a total of 45 days per lifetime per recipient for inpatient hospitalization and a maximum of 15 days per lifetime per recipient for home visitation. Payment for any days in excess of these limitations will be disallowed.

Payment by the KMAP will constitute reimbursement in full and will relieve the Program and the recipient of further liability.

All providers must make fair and equal charges for every person served and in no case may charges for Program recipients or payment on their behalf exceed charges to other patients for the same or similar service.

D. Reimbursement in Relation to Medicare

Recipients who are eligible for both Medicare and Medicaid and who are receiving hospice benefits through the Medicare program may elect to have the five percent co-payment for drugs and respite care reimbursed by the KMAP.

The co-payment reimbursement will be a maximum of 5% per prescription cost of the drug and/or biological and 5% of the payment made by HCFA for a respite care day but may not exceed \$5.00 per day for respite or \$5.00 per prescription.

A copy of the Medicare EOMB must be attached to the UB-82 as well as the invoice for the drugs and/or biologicals to which the five percent co-payment is applied. (Please refer to Section VIII C for billing instructions.)

All forms and enrollment procedures (see Section V for eligibility requirements and Section VIII for completion of forms) which apply to clients who have Medicaid only also apply to clients with both Medicare and Medicaid.

Recipients identified as Qualified Medicare Beneficiaries (QMB) only are eligible only for co-payment for drugs and respite care.

SECTION VII - REIMBURSEMENT

E. Other Third Party Coverage

The 1967 amendments to the Social Security Law stipulate that Title XIX programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of the expenses of the services rendered, that party is primarily liable for the patient's expenses. The KMAP has secondary liability. Accordingly, the provider of service should first seek reimbursement from such third party group. If you as the provider should receive payment from the KMAP before knowing of the third party's liability, a refund of the payment amount should be made to the "Kentucky State Treasurer" and mailed to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Cash/Finance Unit. The amount payable by the Cabinet shall be reduced by the amount of the third party obligations.

1. Identification of Third Party Resources

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

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- If the recipient is married or working, 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 HIC 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.

SECTION VII - REIMBURSEMENT

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

2. Billing Instructions for Claims Involving Third Party Resources

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

Exceptions:

- *If the other insurance company has not made payment within 120 days of date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead form to:

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

- *If proof of denial for the same recipient for the same or related services from the carrier 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 he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

SECTION VII - REIMBURSEMENT

3. Medicaid Payment for Claims Involving a Third Party

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

The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting KMAP payment will be zero. Recipients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers must accept Medicaid payment as payment in full.

Claims for services involving a private insurance company that has made a payment to the recipient can only be paid the difference between the allowable Medicaid rate and the insurance amount paid. The amount paid is to be entered in the appropriate block to enable the claim to pay.

The TPL Lead Form is used in cases where no response has been received from the insurance company and 120 days have elapsed since the submission of the claim. In that case, the claim will be paid at the Medicaid allowable rate and EDS will then pursue collection from the company. An example of the TPL Lead Form may be found in the Appendix Section of this manual, Appendix XV.

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

If you have any questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 333-2188.

SECTION VII - REIMBURSEMENT

F. Client's Continuing Income Liability

If it is determined by the local office of the Department for Social Insurance that a client has income in excess of the monthly eligibility standard, the amount of excess income is to be paid to the provider by the recipient or responsible party and shall be deducted from the Title XIX payments. Notification of the amount of excess income shall be forwarded to the Hospice provider from the Department for Medicaid Services on Form MAP-552. (See Appendix XVI) It is the responsibility of the provider to collect this money from the client.

Providers should continue to bill all covered Hospice services received by the client to the KMAP.

The applicable continuing income will be pro-rated and deducted from Medicaid payments on a per diem basis.

G. Spend Down

Spend down is defined as the utilization of excess income for recognized medical expenses. If a client has income greater than that which is usually permitted for Medicaid eligibility, the local office of the Department for Social Insurance, using a standard computation formula, determines the excess income for a three month period. This quarterly excess is the spend-down amount which must be applied toward incurred or paid medical expenses. The medical card becomes effective on the date on which the quarterly excess income amount is met. Spend down eligibility may be determined for a period three months prior to the application or for a three month period after the application. An MA spend-down eligibility card is a time limited card and requires re-application quarterly.

H. Special Income Provisions

Special income provisions are allowed for Medicaid eligibility for all Hospice clients who are either married or under age eighteen (18). The income and resources of the spouse or parents will be considered available to the Hospice client for the month of admission only.

SECTION VII - REIMBURSEMENT

For the second month and each succeeding month of Hospice participation, only the income and resources of the Hospice client will be used to determine Medicaid eligibility. Additionally, all Hospice clients will be allowed to retain from their own income for their basic maintenance needs an amount equal to the SSI basic benefit rate plus the SSI general disregard.

I. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KMAP, whether due to erroneous billing or payment system faults, must be refunded to the KMAP. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

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

SECTION VIII - COMPLETION OF FORMS

VIII. COMPLETION OF FORMS

A. General

The Uniform Billing Statement (UB-82) is to be used for billing Hospice services rendered to eligible KMAP recipients. A copy of this form may be found in Appendix V of this manual.

A separate billing form is to be used for each patient.

UB-82 billing forms may be obtained from the Kentucky Hospital Association.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered and the election of hospice benefits is in effect. You cannot be paid for services rendered to an ineligible person.

The original of the invoice set should be mailed to:

EDS
P.O. Box 2045
Frankfort, Kentucky 40602

B. Completion of UB-82 MEDICAID ONLY

Following are instructions in form locator order for billing Medicaid services on the UB-82 billing statement (completion of UB-82 for Medicare/Medicaid copayment is found in Section VIII C of this manual). Only instructions for form locators required for EDS processing or KMAP information are included. Instructions for form locators not used by EDS/KMAP processing may be found in the UB-82 Training Manual. The UB-82 Training Manual may be obtained from the Kentucky Hospital Association.

SECTION VIII - COMPLETION OF FORMS

FORM
LOCATOR

1 PROVIDER NAME AND ADDRESS

Enter the complete name and address of the institution.

3 PATIENT CONTROL NUMBER

Enter the patient control number. The first 7 digits will appear on the Remittance Advice.

4 TYPE OF BILL

Enter the applicable 3 digit code that describes type of bill.

1st Digit (Type Facility): 8 = Hospice

2nd Digit (Bill Class): 1 Hospice (Non Hospital Based)
2 Hospice (Hospital Based)

3rd Digit (Frequency): 1 = Admit through discharge claim
2 = Initial billing
3 = Interim billing
4 = Final billing

8 MEDICAID PROVIDER NUMBER

Enter the Hospice Agency's 8 digit Kentucky Medicaid Provider number.

10 PATIENT NAME

Enter the name of the recipient in last name/first name sequence as shown on his/her current Medical Assistance Identification (MAID) card.

15 DATE OF ADMISSION

Enter the date on which the recipient was admitted to the hospice in month, day, year sequence and in numeric format (e.g., 01/03/86).

SECTION VIII - COMPLETION OF FORMS

FORM
LOCATOR

21 PATIENT STATUS CODE

Enter the applicable 2 digit patient status code as of the through date of the billing period.

Code Structure

- 01 - Discharge (left care of this hospice)
- 30 - Still patient of this hospice
- 40 - Died at home
- 41 - Died in a medical facility, such as a hospital, SNF, ICF, or Free Standing Hospice
- 42 - Place of death unknown

22 STATEMENT COVERS PERIOD

From - Enter the beginning date of the billing period covered by this invoice in month, day, year sequence and in numeric format.

Through - Enter the last date of the billing period covered by this invoice in month, day, year sequence and in numeric format.

Do not show days before patient's Medicaid election period began.

28 OCCURRENCE CODE

Enter the 2 digit code that indicates whether the illness was employment or accident related.

Code Structure

UB82 Manual

- 01 Auto Accident
- 02 Auto Accident/No Fault Insurance Involved
- 03 Accident/Last Liability
- 04 Employment Related Accident or Illness
- 05 Other Accident

SECTION VIII - COMPLETION OF FORMS

FORM
LOCATOR

50 DESCRIPTION

Enter a from and through date (within this billing period) in numeric format and in month, day and year sequence for each revenue code shown on the same line in Column 51. PLEASE ENTER SERVICE DATES WITHIN ONE MONTH ONLY ON EACH LINE except in the case of respite care. The entire inpatient respite care stay MUST be entered on ONE line. NOTE: Please complete no more than ten lines per billing statement.

51 REVENUE CODE

Enter the 3 digit revenue code for the service being billed (A LIST OF THE REVENUE CODES ACCEPTED BY KMAP CAN BE FOUND ON PAGES 7.1 AND 7.2 OF THIS MANUAL. Also, see special instructions for billing certain revenue codes on page 8.6 of the manual). Revenue code 001 (Total Charges) must be the last revenue code listed.

52 UNITS

Enter the number of units for each service billed. Units are measured in days for code 653, 182, 183, 184, 185, 654, 651, 655, and 656, in hours for code 652, and in number of prescription drugs for 250. Units for Medicare co-payment are measured in days for 658 and in number of prescriptions for 659.

53 TOTAL CHARGES

Enter the total charges for each revenue code on the same line in column 53. The last revenue code entered in column 51 (001) represents the total of all charges billed, and that total should be the last entry in column 53.

57 PAYER

Enter the name of each payer (e.g. Medicare, Private Insurance, etc.) from which the provider might expect payment.

SECTION VIII - COMPLETION OF FORMS

FORM
LOCATOR

63 PRIOR PAYMENTS

Enter the total amount (if any) received from private insurance (the amount should be listed on the corresponding line with the payer in #57). NEITHER Medicare payment amount, Medicaid payment amount, nor the recipient continuing income amount is to be entered.

65 INSURED'S NAME - REQUIRED ENTRY

Enter the name of the recipient in last name/first name sequence as shown on his/her current MAID card.

68 MEDICAL ASSISTANCE ID NUMBER

Enter the recipient's 10 digit identification number EXACTLY as shown on his/her current MAID card.

77 PRIMARY DIAGNOSIS CODE

Enter the ICD-9 diagnosis code for which the patient is receiving treatment.

78
THRU
81

OTHER DIAGNOSIS CODES

Enter other ICD-9 diagnosis codes (if any) for which the patient is receiving treatment.

92 ATTENDING PHYSICIAN ID

Enter the 5 digit license number of the attending physician.

SECTION VIII - COMPLETION OF FORMS

FORM
LOCATOR

95 PROVIDER CERTIFICATION - Required

Enter the actual signature (not a facsimile) of the invoicing provider or the provider's duly appointed representative. STAMPED SIGNATURES ARE NOT ACCEPTED.

96 INVOICE DATE

Enter the date in month, day, year sequence and in numeric format on which this invoice was signed and submitted to EDS for processing.

SPECIAL INSTRUCTIONS FOR SPECIFIC REVENUE CODES

653 Room and Board SNF - Charges for room and board must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 653 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

654 Room and Board ICF - Charges for room and board must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 654 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

182 ICF Bed Reservation Days Home - Charges for ICF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 182 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

183 SNF Bed Reservation Days Home - Charges for SNF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 183 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

SECTION VIII - COMPLETION OF FORMS

- 184 ICF Bed Reservation Days Hospital - Charges for ICF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 184 must be billed with 656 (General Inpatient Care).
- 185 SNF Bed Reservation Days Hospital - Charges for SNF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 185 must be billed with 656 (General Inpatient Care).
- 655 Inpatient Respite Care - The entire inpatient respite care MUST be entered on one line.

NOTE: Claims with services dates more than twelve (12) months old can be considered for processing ONLY with appropriate documentation such as one or more of the following: Remittance statements no more than 12 months of age which verify timely filing, backdated MAID cards (the words "backdated card" should be written on the claim form and on the copy of the backdated MAID card), Social Security documents, correspondence describing extenuating circumstances, Return to Provider Letters, Medicare EOMB's etc. Without such documentation, claims over 12 months old will be denied.

C. Completion of UB-82 for Medicare Co-Payment

Following are instructions for billing the Medicare co-payment on the UB-82 billing statement. All form locators should be completed as outlined in Section VIII B of this manual with the following exceptions.

FORM
LOCATOR

50

DESCRIPTION

Enter a from and to date (within this billing period) in numeric format and in month, day and year sequence for each revenue code shown on the same line in Column 51. The line item dates of service for the prescription co-payment must reflect the from and to days covered by the prescription.

SECTION VIII - COMPLETION OF FORMS

51 REVENUE CODE

Enter the 3 digit revenue code for the service being billed.

1. Respite Care Co-Payment
 - a. Revenue Code: 658
 - b. Unit of Service: 1 day (24 hours)
2. Hospice Drug Co-Payment
 - a. Revenue Code: 659
 - b. Unit of Service: 1 prescription = 1 unit

52 UNITS

Enter the number of units for each service billed. Units are measured in days for code 658 and in number of prescription for 659. Since Medicare does not allow payment for more than five (5) consecutive days of respite care, DO NOT bill for more than five (5) units for 658. Note: In the case of co-payment for drugs, the number of units will not always equal the number of days covered in the date span for the service.

A copy of the applicable Explanation of Medicare Benefits (EOMB) and a drug invoice (when applicable) must be attached to the UB-82. It is not necessary to attach a copy of the EOMB if only charges for room and board are being billed.

All other pertinent criteria for hospice coverage must be met.

NOTE: For patients with both Medicare and Medicaid, when billing for service dates which include charges for co-payments (drug and/or respite) and room and board or board reservation days all charges should be billed on the same UB-82. If no co-payment is being billed, charges for room and board and/or bed reservation days may be billed alone.

SECTION VIII - COMPLETION OF FORMS

D. Completion of Election of Medicaid Hospice Benefit Form (MAP-374)

An individual who meets the eligibility requirements for hospice care and elects to receive that care, must file an Election of Medicaid Hospice Benefits Form (MAP-374) with the particular hospice agency who will be providing the care.

The name of the individual, the MAID number, the name and provider number of the hospice agency and the effective date that hospice care begins must be entered in the appropriate spaces on the MAP-374, as well as the name of the agency who will be providing outpatient medication.

The effective date for the election period may begin with the first day of hospice care or any subsequent day of hospice care. The effective date may not be prior to the date that the election is made.

The election to receive hospice care will be considered to continue as long as the individual remains in the care of the hospice and does not revoke the election of hospice benefits. The MAP-374 will remain in effect for the duration of hospice care.

The section of the MAP-374 regarding Medicare eligibility must be completed appropriately and if Medicare eligible, the dates of Medicare eligibility must be entered. NOTE: If an individual is not eligible for Medicare benefits at the time the Medicaid hospice benefit begins but begins his/her Medicare benefits during the Medicaid benefit period, the hospice agency should send a Hospice Patient Status Change Form (MAP-403) to the Department for Medicaid Services and the local Department for Social Insurance Office indicating the date that Medicare benefits became effective. Failure to submit this information will result in incorrect payment of claims.

The section of the MAP-374 pertaining to long term care facility residents must be completed if the patient is a resident in a long term care facility at the time he/she elects the Medicaid hospice benefit. The name of the facility and the type of facility (skilled nursing or intermediate care) must be entered. If a patient enters a long term care facility during the Medicaid hospice benefit period, the hospice agency should send a Hospice Patient Status Change Form (MAP-403) to the Department for Medicaid Services and to the local

SECTION VIII - COMPLETION OF FORMS

Department for Social Insurance Office indicating the name and type of the facility in the appropriate space and the date on which the patient was admitted to the facility. Failure to submit this information could result in the incorrect determination of the patient's eligibility.

The MAP-374 must be signed and dated by the individual (or authorized representative) and a witness.

If an individual revokes the election of hospice benefits and later elects to receive hospice benefits again, the second certification section of the MAP-374 must be completed with the signature of the individual (or authorized representative) and a witness, as well as the effective date that the second election period will begin. Requirements for the second election period are the same as those for the initial election period. If an individual revokes the election of hospice benefits during the second election period and later elects to receive hospice benefits again, the third certification section of the MAP-374 must be completed with the signature of the individual (or authorized representative) and a witness, as well as the effective date that the third election period begins. Requirements for the third election period are the same as those for the initial and second election periods.

The second and third certification sections of the MAP-374 need not be completed if the previous benefit has not been revoked.

A copy of the MAP-374 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the election period. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-374 may be found in the Appendix Section of this manual, Appendix VI.

SECTION VIII - COMPLETION OF FORMS

E. Completion of Revocation of Medicaid Hospice Benefit Form (MAP-375)

If an individual chooses to revoke his/her Medicaid hospice benefits, he/she must file a Revocation of Medicaid Hospice Benefits Form (MAP-375) with the particular hospice agency who has been providing the hospice care.

The name of the individual, the MAID number, and the name and provider number of the hospice agency must be entered in the appropriate spaces on the MAP-375, as well as the effective date that the revocation begins and the individual resumes his/her regular Medicaid coverage. The effective date of the revocation may not be prior to the date that the revocation is made.

The MAP-375 must be signed and dated by the individual (or authorized representative) as well as a witness. Additionally, the hospice agency staff should complete the Rationale of Revocation section of the MAP-375.

A copy of the MAP-375 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the revocation. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-375 may be found in the Appendix Section of this manual, Appendix VII.

SECTION VIII - COMPLETION OF FORMS

F. Completion of Change of Hospice Providers Form (MAP-376)

If an individual chooses to change from one hospice agency to another for hospice care, he/she must file a Change of Hospice Providers Form (MAP-376) with both the hospice agency which has been providing care and the hospice agency which will begin providing care.

The name of the individual, the MAID number, the name and provider number of both hospice agencies and the effective date that the change of providers begins must be entered in the appropriate spaces on the MAP-376. (NOTE: A change in hospice providers is NOT a revocation of hospice benefits.)

The MAP-376 must be signed and dated by the individual (or authorized representative) and a witness.

A copy of the MAP-376 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the change. A copy must also be retained by each hospice agency.

A copy of the original MAP-374 should be sent to the new hospice agency along with the Change of Hospice Providers Form (MAP-376).

Failure to complete forms correctly may result in delays in payment.

An example of the Change of Hospice Providers Form (MAP-376) may be found in the Appendix Section of this manual, Appendix VIII.

SECTION VIII - COMPLETION OF FORMS

G. Completion of Termination of Medicaid Hospice Benefits
Form (MAP-378)

If hospice benefits for an individual are terminated for any reason, a Termination of Medicaid Hospice Benefits Form (MAP-378) must be filed by the hospice agency which has been providing hospice care.

The name of the individual, the MAID number, the effective date of the termination and the name and provider number of the hospice agency must be entered in the appropriate spaces on the MAP-378.

The block which indicates the reason for termination must be checked. If patient is deceased, the date of death must be entered. If "Other" is checked an explanation of the reason for termination must be included.

This form may also be used if a patient becomes inactive. The date the patient became inactive must be entered, and the block "Condition Improved. Patient in Long Term Inactive Status" must be checked.

(NOTE: Termination of hospice benefits is NOT a revocation of benefits.)

The MAP-378 must be signed and dated by the hospice medical director.

A copy of the MAP-378 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the termination. A copy must also be retained by the hospice agency.

An example of the MAP-378 may be found in the Appendix Section of this manual, Appendix X.

SECTION VIII - COMPLETION OF FORMS

H. Completion of Representative Statement For Election of Hospice Benefits (MAP-379)

If an individual is unable, due to physical and/or mental incapacity, to act on his/her own behalf, a legal representative may be appointed. The legal representative may sign any or all hospice forms on behalf of the individual. The name of the representative and the name of the individual and the MAID number must be entered in the appropriate spaces on the MAP-379.

The MAP-379 must be signed and dated by the legal representative and a witness.

The MAP-379 need only be completed once, at the time the representative begins acting on behalf of the individual; a copy of the completed MAP-379 must, however, accompany all other forms which the legal representative has signed on behalf of the individual.

A copy of the MAP-379 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the date when the representative begins acting on behalf of the individual. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-379 may be found in the Appendix Section of this manual, Appendix XI.

I. Completion of the Other Hospitalization Statement (MAP-383)

If a hospice recipient is hospitalized for any condition not related to the terminal illness, an Other Hospitalization Statement (MAP-383) must be completed. The name of the hospital to which the recipient is being admitted, the name and MAID number of the recipient and the actual date of the hospital admission should be entered in the appropriate spaces. The Diagnosis and the ICD 9 CM code for this hospitalization must be entered. The Diagnosis and the ICD 9 CM

SECTION VIII - COMPLETION OF FORMS

code for the patient's terminal illness must be entered. The appropriate block regarding previous hospitalizations must be checked and the dates, diagnoses and ICD 9 CM codes for previous admissions must be entered when applicable. The form must be signed and dated by the medical director of the hospice. The form should be sent to the KMAP for review along with documentation which includes the terminal diagnosis, the patient's present condition and verification that the reason for this hospitalization is in NO way related to the terminal illness. After review by the KMAP, the form will be returned to the hospice agency marked "Approved by the KMAP" or "Denied by the KMAP" and signed by a KMAP representative. If approved, one copy should be sent to the admitting hospital and one copy should be retained by the hospice agency. Hospice services may not be billed during the period of hospitalization. If denied, the hospice agency must bill for the service using the revenue code for General Inpatient Care.

An example of the Other Hospitalization Statement (MAP-383) may be found in Appendix XVII of this manual.

J. Completion of Hospice Drug Form (MAP-384)

If a hospice recipient requires drugs which are not related to his/her terminal illness, a Hospice Drug Form (MAP-384) must be completed and submitted to the KMAP with the Election of Benefits Form (MAP-374). Instructions for completion of the form are as follows:

BLOCK
NO.

1 RECIPIENT LAST NAME

Enter the last name of the recipient

2 FIRST NAME

Enter the first name of the recipient

SECTION VIII - COMPLETION OF FORMS

3 MEDICAL ASSISTANCE I.D. NUMBER

Enter the recipient's MAID Number exactly as it appears on his/her current MAID card.

4 DATE MEDICAID HOSPICE COVERAGE BEGAN

Enter the actual date Medicaid hospice coverage for this recipient began. The date must agree with the effective date of the Election of Benefits Form (MAP-374).

5 FIRST DIAGNOSIS (Not Related to the Terminal Illness)

Enter the diagnosis for the condition which requires the prescriptions; enter the ICD-9-CM code for the diagnosis.

SECOND DIAGNOSIS (Not Related to the Terminal Illness)

Enter the second diagnosis (if any) for the condition which requires the prescription; enter the ICD-9-CM code for the diagnosis.

6. TOTAL NUMBER OF PRESCRIPTIONS NOT RELATED TO TERMINAL ILLNESS

Enter the total number of prescriptions not related to the terminal illness.

7 DRUG NAME

Enter the name and strength (10 mg. 100 mg.) of the drug

8 NDC

Enter the NDC for the drug

9 UNITS

Enter the number of units required

10 PRICE PER UNIT

Enter the actual price per unit

SECTION VIII - COMPLETION OF FORMS

- 11 TOTAL CHARGE
Enter the total charge for this prescription
- 12 MEDICAID MAXIMUM ALLOWABLE
Leave Blank
- 13 TOTAL UNITS THIS INVOICE
Enter the total number of prescriptions requested on this invoice
- 14 TOTAL CHARGE THIS INVOICE
Enter the total charge for all prescriptions requested on this invoice
- 15 TERMINAL DIAGNOSIS
Enter the terminal diagnosis of the patient and the ICD 9 CM code for that diagnosis.
- 16 PREVIOUSLY REQUIRED PRESCRIPTIONS
Enter whether the patient required these prescriptions prior to the diagnosis of the terminal illness.
- 17 PRESCRIPTIONS RESULTING FROM HOSPITALIZATION
Enter whether the prescriptions are the result of a hospitalization not related to the terminal illness.
- 18 DATES OF HOSPITALIZATION
If "yes" is checked in block 17, enter the dates of that hospitalization.
- 19 NAME OF HOSPITAL
If "yes" is checked in block 17, enter the name of the hospital.

SECTION VIII - COMPLETION OF FORMS

20 PRESCRIBING PHYSICIAN

Enter the name of the physician prescribing these drugs.

21 PROVIDER CERTIFICATION AND SIGNATURE

The actual signature of the provider (not a facsimile) or the provider's authorized agent is required

22 PROVIDER NAME AND ADDRESS

Enter the complete name and address of the hospice agency

23 PROVIDER NUMBER

Enter the 8 digit Medicaid provider number of the hospice agency.
The number must begin with "44."

24 INVOICE DATE

Enter the date on which this invoice was signed and submitted to the KMAP.

25 INVOICE NUMBER

No entry required

Both copies of the MAP-384 should be attached to the Election of Benefits Form (MAP-374). Documentation must also be attached which verifies that the need for these prescriptions/items is in NO way related to the patient's terminal illness. One copy will be returned to the provider by the KMAP with the allowable maximum Medicaid payment entered in Block 12 for each prescription. If payment is not allowed, "NA" will be entered in Block 12.

Only one MAP-384 need be submitted unless the hospice benefit is revoked or unless there is a change in the prescriptions required. The initial MAP-384 should be submitted with the recipient's Election of Benefit Form (MAP-374). If the hospice benefit is revoked and then reinstated, a new MAP-384 should be sent with the second or third certification period. If there is a change in the prescriptions required, an MAP-384 only should be submitted. The hospice agency should retain a copy of the invoice.

SECTION VIII - COMPLETION OF FORMS

The MAP-384 should also be used when requesting prior approval for additional payment for nutritional supplements when they are required for the total nutrition of the patient. The form should be completed as for regular prescriptions with the name of the nutritional supplement entered in block 7 and the NDC number entered in block 8. Documentation from the attending physician which verifies that the nutritional supplements are required for the patient's total nutrition must be attached to the MAP-384.

An example of the MAP-384 may be found in Appendix XVIII of this manual.

K. Completion of Other Services Statement (MAP-397)

For those services which are usually covered under the hospice benefit but are being billed separately because they have been determined to be totally unrelated to the terminal illness of the patient, an Other Services Statement (MAP-397) must be completed in order to obtain approval from the KMAP. Instructions for completion of the form are as follows:

1. The name of the agency providing the service, the name and MAID number of the recipient and the date of service must be entered in the appropriate spaces.
2. The diagnosis of the condition requiring this service and the ICD 9 CM code for that diagnosis must be entered.
3. The diagnosis and ICD 9 CM code of the patient's terminal illness must be entered.
4. Items of durable medical equipment being billed separately must be specifically identified.
5. A description of hospital outpatient services and the reason for the services must be entered.
6. The form must be signed and dated by the medical director of the hospice agency.
7. Documentation which verifies that the services are totally unrelated to the terminal illness of the patient must be attached to the form.

SECTION VIII - COMPLETION OF FORMS

8. All copies of the form should be submitted to the Department for Medicaid Services, Division of Policy and Provider Services. Two copies of the form will be returned to the provider signed by a KMAP representative indicating whether separate payment for the services has been approved or denied.
9. If approved, one copy of the form should be sent to the provider who will bill for the service. The other copy should be retained by the hospice agency.

An example of the Other Services Statement (MAP-397) may be found in Appendix XIX of this manual.

SECTION VIII - COMPLETION OF FORMS

L. Completion of Hospice Patient Status Change Form (MAP-403)

This form should be used any time a patient's status changes in any way after the Election of Medicaid Benefits Form (MAP-374) is filed.

Enter the patient's name and MAID number.

Enter the name and provider number of the hospice agency.

Enter the original date of election of Medicaid hospice benefits.

Enter the effective date of this change.

Check the block which appropriately describes this change and all information pertaining to the change.

The form must be signed by the patient or his/her authorized representative and a Hospice Agency Representative.

A copy of the MAP-403 must be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the change. A copy must also be retained by the hospice agency.

Failure to complete the form correctly may result in delays in payment.

An example of the MAP-403 may be found in the Appendix Section of this manual, Appendix IX.

SECTION IX - REMITTANCE STATEMENT

IX. REMITTANCE STATEMENT

A. General

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

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

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

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

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

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

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

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

SECTION IX - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix XII-P1. This section lists all of those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT
FOR HOSPICE SERVICES

| <u>ITEM</u> | |
|----------------------|--|
| INVOICE NUMBER | The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference |
| RECIPIENT NAME | The name of the recipient as it appears on the Department's file of eligible Medicaid recipients |
| RECIPIENT NUMBER | The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider |
| INTERNAL CONTROL NO. | The internal control number (ICN) assigned to the claim for identification purposes by EDS. |
| CLAIM SVC DATE | The earliest and latest dates of service as shown on the claim form |
| TOTAL CHARGES | The total charges billed by the provider for the services on this claim form |
| CHARGES NOT COVRD | Any portion of the provider's billed charges that are not being paid, (examples: rejected line item, reduction in billed amount to allowed charge) |
| AMT. FROM OTHER SRCS | The amount indicated by the provider as received from a source other than the Medicaid program for services on the claim |

SECTION IX - REMITTANCE STATEMENT

| | |
|---------------------|---|
| CLAIM PMT AMOUNT | The amount being paid by the Medicaid Program to the provider for this claim |
| EOB | For explanation of benefit code, see back page of Remittance Statement |
| LINE NO. | The number of the line on the claim being printed |
| PS | Place of service code depicting the location of the rendered service |
| REV CODE | The revenue code in the line item |
| QTY | The number of procedures/supply for that line item charge |
| LINE ITEM CHARGE | The charge submitted by the provider for the procedure in the line item |
| LINE ITEM PMT | The amount being paid by the Medicaid program to the provider for a particular line item |
| EOB | Explanation of benefit code which identifies the payment process used to pay the line item. |

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix XII-P2

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

SECTION IX - REMITTANCE STATEMENT

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix XII-P3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim only appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix XII-P4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

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

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

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

SECTION IX - REMITTANCE STATEMENT

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

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix XII-P5).

SECTION X - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

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

| <u>Type of Information Requested</u> | <u>Necessary Information</u> |
|--------------------------------------|---|
| Inquiry | <ol style="list-style-type: none"> 1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time |

SECTION X - GENERAL INFORMATION - EDS

| <u>Type of Information Requested</u> | <u>Necessary Information</u> |
|--------------------------------------|--|
| Adjustment | <ol style="list-style-type: none">1. Completed Adjustment Form2. Photocopy of the claim in question3. Photocopy of the applicable portion of the R/A in question |
| Refund | <ol style="list-style-type: none">1. Refund Check2. Photocopy of the applicable portion of the R/A in question3. Reason for refund |

B. Telephoned Inquiry Information

What is Needed?

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

When to Call?

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

Where to Call?

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

SECTION X - GENERAL INFORMATION - EDS

C. Filing Limitations

New Claims - 12 months from date of service

Medicare/Medicaid
Crossover Claims - 12 months from date of service

NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.

Third-Party
Liability Claims - 12 months from date of service

NOTE: If the other insurance company has not responded within 120 days of date of service, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.

Adjustments - 12 months from date the paid claim appeared on the R/A

SECTION X - GENERAL INFORMATION - EDS

D. Provider Inquiry Form

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

EDS
P.O. Box 2009
Frankfort, KY 40602

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

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

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

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

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

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

SECTION X - GENERAL INFORMATION - EDS

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

| <u>Field Number</u> | <u>Instructions</u> |
|---------------------|---|
| 1 | Enter your 8-digit Kentucky Medicaid Provider Number. If you are a KMAP certified clinic, enter your 8 digit clinic number. |
| 2 | Enter your Provider Name and Address. |
| 3 | Enter the Medicaid Recipient's Name as it appears on the Medical Assistance I.D. Card. |
| 4 | Enter the recipient's 10 digit Medical Assistance ID number. |
| 5 | Enter the Billed Amount of the claim on which you are inquiring. |
| 6 | Enter the Claim Service Date(s). |
| 7 | If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim. |
| 8 | If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13 digit internal control number listed on the Remittance Advice for that particular claim. |
| 9 | Enter your specific inquiry. |
| 10 | Enter your signature and date of the inquiry. |

SECTION X - GENERAL INFORMATION - EDS

E. Adjustment Request Form

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

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

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

SECTION X - GENERAL INFORMATION - EDS

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

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

To reorder these forms, contact the 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.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

HOSPICE PROGRAM MANUAL

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

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

DENTAL SERVICES

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

DURABLE MEDICAL EQUIPMENT

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

FAMILY PLANNING SERVICES

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

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

HEARING SERVICES

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

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KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOME HEALTH SERVICES

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

HOSPITAL SERVICES

INPATIENT SERVICES

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

OUTPATIENT SERVICES

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

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

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KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

LABORATORY SERVICES

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

LONG TERM CARE FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES

The KMAP can make payment to skilled nursing facilities for:

- A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis.*
- B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.

-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

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

INTERMEDIATE CARE FACILITY SERVICES

The KMAP can make payment to intermediate care facilities for:

- A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*
- B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.*

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

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KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

MENTAL HOSPITAL SERVICES

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

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
- 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. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

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

NURSE MIDWIFE SERVICES

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

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KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHARMACY SERVICES

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

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

PHYSICIAN SERVICES

Covered services include:

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

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

Non-covered services include:

Injections, supplies, drugs (except 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:

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

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HOSPICE PROGRAM MANUAL

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHYSICIAN SERVICES (Continued)

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

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

PODIATRY SERVICES

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

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KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PRIMARY CARE SERVICES

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

RENAL DIALYSIS CENTER SERVICES

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

RURAL HEALTH CLINIC SERVICES

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

SCREENING SERVICES

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

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

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KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

TRANSPORTATION SERVICES

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

VISION SERVICES

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

****SPECIAL PROGRAMS****

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

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

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

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HOSPICE PROGRAM MANUAL

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HOSPICE:

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

TARGETED CASE MANAGEMENT SERVICES:

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

CABINET FOR HUMAN RESOURCES
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ELIGIBILITY INFORMATION

Programs

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

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

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

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

CABINET FOR HUMAN RESOURCES
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ELIGIBILITY INFORMATION

MAID Cards

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

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

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

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

Verifying Eligibility

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

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

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

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP 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.

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

Medical Insurance Code indicates type of insurance coverage.

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

| MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES | | Members Eligible for Medical Assistance Benefits | Medical Assistance Identification Number | SEX | DATE OF BIRTH MO-YR | INS. |
|--|--|--|--|--------|---------------------------|--------|
| ELIGIBILITY PERIOD FROM: 06-01-85 TO: 07-01-85 CASE NUMBER 037 C 000123456 | | Smith, Jane Smith, Kim | 1234567890 2345678912 | 2 2 | 0353 1284 | M M |
| CASE NAME AND ADDRESS ISSUE DATE: 12-27-88 Jane Smith 400 Block Ave. Frankfort, KY 40601 | | | | | | |
| ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS | | | | | | |
| SEE OTHER SIDE FOR SIGNATURE | | MAP 520A REV 6/88 | | | | |

Date card was issued

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

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

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

(BACK OF CARD)

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

This card certifies that the person(s) listed herein is /are 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.

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 Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

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

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. 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 persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

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 ~~file~~ 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.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

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.

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

Name and provider number of Lock-In physician. KMAP payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the KMAP).

| | | |
|---|---|------------------------|
| MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES | | |
| ATTENTION SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS | | |
| FROM ELIGIBLE RECIPIENT & ADDRESS | TO ELIGIBILITY PERIOD | PHYSICIAN NAME |
| | MEDICAL ASSISTANCE IDENTIFICATION NUMBER | PHYSICIAN PROVIDER NO. |
| | SEX CODE | |
| | INSURANCE | PHARMACY NAME |
| | DATE OF BIRTH MONTH YEAR | PHARMACY PROVIDER NO. |
| | CASE NUMBER | |
| SEE OTHER SIDE FOR SIGNATURE | MAP 520A REV 11/86 | |

Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently
Left Blank

Insurance
Code

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

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services; however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In coordinator by calling 502-664-5560.

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.

Insurance Identification

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

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

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.

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(FRONT OF CARD)

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.

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 KMAP. Persons whose names are in this block have the Primary Care provider listed on this card.

| MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES | | Members Eligible for Medical Assistance Benefits | Medical Assistance Identification Number | SEX | DATE OF BIRTH MO-YR | INS. |
|---|--------------|--|--|-----------------------|---------------------------|------|
| ELIGIBILITY PERIOD | | CASE NUMBER | | | | |
| FROM: | 06 - 01 - 85 | 037 C 000123456 | | | | |
| TO: | 07 - 01 - 85 | | | | | |
| ISSUE DATE: 12-27-88 | | CASE NAME AND ADDRESS | | | | |
| Jane Smith 400 Block Ave. Frankfort, KY 40601 | | KENTPAC PROVIDER AND ADDRESS | | | | |
| ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS | | Warren Peace, M.D. 1010 Tolstoy Lane Frankfort, KY 40601 | | 502-346-9832 PHONE | | |
| SEE OTHER SIDE FOR SIGNATURE | | MAP 520K (6-84) | | | | |

Date card was issued

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

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

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

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(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.

| | | | | | | | | | | | | | | | |
|---|---|-------------------------|------------|-------------------------|-----------------------------------|-----------------------------|--------------------------|---------------------------|-----------------------------|---|--------|-----------------------------|-----------------------|--|--------------|
| <p>PROVIDERS OF SERVICE</p> <p>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.</p> <p>NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Services."</p> <p>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, KY 40621</p> | <p>RECIPIENT OF SERVICES</p> <ol style="list-style-type: none"> The designated KenPAC primary provider must provide or authorize the following services: physician, hospital in-patient and out-patient, home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, and nurse anesthetist. Authorization by the primary provider is not required for services provided by ophthalmologists or board eligible or board certified psychiatrists, for obstetrical services provided by an obstetrician or gynecologist, or for other covered services not listed above. In the event of an emergency, payment can be made to a participating medical provider rendering service to the person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse residences, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers. Show this card to the person who provides these services to you whenever you receive medical care. 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 the card except the person listed on the front of this card. If you have questions, contact your eligibility worker at the county office. Recipient (s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. <p>_____ Signature</p> | | | | | | | | | | | | | | |
| <p>Insurance Identification</p> <table border="0"> <tr> <td>A—Part A, Medicare Only</td> <td>G—Charmpus</td> </tr> <tr> <td>B—Part B, Medicare Only</td> <td>H—Health Maintenance Organization</td> </tr> <tr> <td>C—Both Parts A & B Medicare</td> <td>J—Other and / or Unknown</td> </tr> <tr> <td>D—Blue Cross /Blue Shield</td> <td>L—Absent Parent's Insurance</td> </tr> <tr> <td>E—Blue Cross /Blue Shield Major Medical</td> <td>M—None</td> </tr> <tr> <td>F—Private Medical Insurance</td> <td>N—United Mine Workers</td> </tr> <tr> <td></td> <td>P—Black Lung</td> </tr> </table> <p>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.</p> | | A—Part A, Medicare Only | G—Charmpus | B—Part B, Medicare Only | H—Health Maintenance Organization | C—Both Parts A & B Medicare | J—Other and / or Unknown | D—Blue Cross /Blue Shield | L—Absent Parent's Insurance | E—Blue Cross /Blue Shield Major Medical | M—None | F—Private Medical Insurance | N—United Mine Workers | | P—Black Lung |
| A—Part A, Medicare Only | G—Charmpus | | | | | | | | | | | | | | |
| B—Part B, Medicare Only | H—Health Maintenance Organization | | | | | | | | | | | | | | |
| C—Both Parts A & B Medicare | J—Other and / or Unknown | | | | | | | | | | | | | | |
| D—Blue Cross /Blue Shield | L—Absent Parent's Insurance | | | | | | | | | | | | | | |
| E—Blue Cross /Blue Shield Major Medical | M—None | | | | | | | | | | | | | | |
| F—Private Medical Insurance | N—United Mine Workers | | | | | | | | | | | | | | |
| | P—Black Lung | | | | | | | | | | | | | | |

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

Recipient's signature is not required.

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

(FRONT OF CARD)

Eligibility period is the month, day and year of QMB 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.

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

Medical Insurance Code indicates type of insurance coverage.

Red

Blue

| LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES | | |
|--|-----------------------------|--|
| ELIGIBLE RECIPIENT AND ADDRESS | ELIGIBILITY PERIOD | COVERAGE IS LIMITED TO: |
|  Jane Smith 400 Block Ave. Frankfort, KY 40601 | FROM: | * MEDICARE PART B PREMIUMS * MEDICARE CO-INSURANCE * MEDICARE DEDUCTIBLES SEE REVERSE SIDE FOR ADDITIONAL INFORMATION |
| | TO: | |
| | MEDICAID QMB ID. NO. | |
| | SEX CODE | |
| | INSURANCE ID. | |
| | DATE OF BIRTH MONTH/YEAR | |
| ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE | | PLEASE SIGN IMMEDIATELY |
| MAP 520-C REV (1-89) | | |

Name of member eligible to be a Qualified Medicare Beneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

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

(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 QMB.

| PROVIDERS OF SERVICE | RECIPIENT OF SERVICES | | | | | | | | | | | | | | |
|---|--|-------------------------|-----------|-------------------------|-----------------------------------|-----------------------------|--------------------------|---------------------------|-----------------------------|---|--------|-----------------------------|-----------------------|--|--------------|
| <p>1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-insurance and Deductibles only.</p> <p>2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:</p> <p style="text-align: center;">Cabinet for Human Resources Department for Medicaid Services 275 East Main Street Frankfort, KY 40621-0001</p> | <p>1. Show the card whenever you receive medical care.</p> <p>2. 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 front of the card immediately.</p> <p>3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</p> <p>4. If you have questions, contact your case worker at the Department for Social Insurance County office.</p> | | | | | | | | | | | | | | |
| <p style="text-align: center;">Insurance Identification</p> <table border="0"> <tr> <td>A—Part A, Medicare Only</td> <td>G—Champus</td> </tr> <tr> <td>B—Part B, Medicare Only</td> <td>H—Health Maintenance Organization</td> </tr> <tr> <td>C—Both Parts A & B Medicare</td> <td>J—Other and / or Unknown</td> </tr> <tr> <td>D—Blue Cross /Blue Shield</td> <td>L—Absent Parent's Insurance</td> </tr> <tr> <td>E—Blue Cross /Blue Shield Major Medical</td> <td>M—None</td> </tr> <tr> <td>F—Private Medical Insurance</td> <td>N—United Mine Workers</td> </tr> <tr> <td></td> <td>P—Black Lung</td> </tr> </table> | | A—Part A, Medicare Only | G—Champus | B—Part B, Medicare Only | H—Health Maintenance Organization | C—Both Parts A & B Medicare | J—Other and / or Unknown | D—Blue Cross /Blue Shield | L—Absent Parent's Insurance | E—Blue Cross /Blue Shield Major Medical | M—None | F—Private Medical Insurance | N—United Mine Workers | | P—Black Lung |
| A—Part A, Medicare Only | G—Champus | | | | | | | | | | | | | | |
| B—Part B, Medicare Only | H—Health Maintenance Organization | | | | | | | | | | | | | | |
| C—Both Parts A & B Medicare | J—Other and / or Unknown | | | | | | | | | | | | | | |
| D—Blue Cross /Blue Shield | L—Absent Parent's Insurance | | | | | | | | | | | | | | |
| E—Blue Cross /Blue Shield Major Medical | M—None | | | | | | | | | | | | | | |
| F—Private Medical Insurance | N—United Mine Workers | | | | | | | | | | | | | | |
| | P—Black Lung | | | | | | | | | | | | | | |
| <p>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.</p> <p>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.</p> | | | | | | | | | | | | | | | |

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

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP 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.

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

Medical Insurance Code indicates type of insurance coverage.

NOTICE
OMB
Info.

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

Date card was issued

| MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES | | Members Eligible for Medical Assistance Benefits | Medical Assistance Identification Number | SEX | DATE OF BIRTH MO-YR | INS. |
|---|--------------|--|--|-----|---------------------------|------|
| ELIGIBILITY PERIOD | | ... THIS PERSON IS ALSO ELIGIBLE FOR OMB BENEFITS ... | | | | |
| FROM: | 06 - 01 - 89 | Smith, Jane Smith, Kim | 1234567890 2345678912 | 2 | 0353 | M |
| TO: | 07 - 01 - 89 | | | | | |
| CASE NUMBER 037 C 000123456 | | CASE NAME AND ADDRESS | | | | |
| ISSUE DATE: 12-27-81 | | Jane Smith 400 Block Ave. Frankfort, KY 40601 | | | | |
| ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS | | | | | | |
| SEE OTHER SIDE FOR SIGNATURE | | MAP 520 REV 8/88 | | | | |

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P.
Statistical
Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

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

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

(BACK OF CARD)

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

| | | | | | | | | | | | | | | | |
|---|--|-----------|------------------------|-----------------------------------|-----------------------------|------------------------|--------------------------|-----------------------------|--|--------|-----------------------------|-----------------------|--|--------------|---|
| <p>This card certifies that the person(s) listed herein is /are 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.</p> <p>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 Social Insurance Division of Medical Assistance Frankfort, KY 40621</p> | <p>RECIPIENT OF SERVICES</p> <ol style="list-style-type: none">1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.3. 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 persons listed on the front of this card.4. If you have questions, contact your eligibility worker at the county office.5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. <p>_____ Signature</p> | | | | | | | | | | | | | | |
| <p>Insurance Identification</p> <table><tr><td>A Part A Medicare Only</td><td>G Champus</td></tr><tr><td>B Part B Medicare Only</td><td>H Health Maintenance Organization</td></tr><tr><td>C Both Parts A & B Medicare</td><td>J Other and or Unknown</td></tr><tr><td>D Blue Cross Blue Shield</td><td>L Absent Parent's Insurance</td></tr><tr><td>E Blue Cross Blue Shield Major Medical</td><td>M None</td></tr><tr><td>F Private Medical Insurance</td><td>N United Mine Workers</td></tr><tr><td></td><td>P Black Lung</td></tr></table> | A Part A Medicare Only | G Champus | B Part B Medicare Only | H Health Maintenance Organization | C Both Parts A & B Medicare | J Other and or Unknown | D Blue Cross Blue Shield | L Absent Parent's Insurance | E Blue Cross Blue Shield Major Medical | M None | F Private Medical Insurance | N United Mine Workers | | P Black Lung | <p>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 or to report changes relating to eligibility or permits use of the card by an ineligible person.</p> |
| A Part A Medicare Only | G Champus | | | | | | | | | | | | | | |
| B Part B Medicare Only | H Health Maintenance Organization | | | | | | | | | | | | | | |
| C Both Parts A & B Medicare | J Other and or Unknown | | | | | | | | | | | | | | |
| D Blue Cross Blue Shield | L Absent Parent's Insurance | | | | | | | | | | | | | | |
| E Blue Cross Blue Shield Major Medical | M None | | | | | | | | | | | | | | |
| F Private Medical Insurance | N United Mine Workers | | | | | | | | | | | | | | |
| | P Black Lung | | | | | | | | | | | | | | |

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

Recipient's signature is not required.

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

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

(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

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

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

(Type of Provider and/or level of care)

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

1. The Provider:

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

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

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

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

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

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

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

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

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

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

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

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

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

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

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

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

PROVIDER

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

BY: _____
Signature of Authorized Official

NAME: _____

NAME: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

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

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

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

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

shall (1) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

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

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

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

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

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

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

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

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

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

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

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

(d) Whoever knowingly and willfully--

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

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

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

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

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

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. KMAP 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):

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

Name: _____

Address: _____

Telephone Number: _____

Name and Address of Officers:

17. If Partnership, name and address of Partners:

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

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

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:

| | <u>Name</u> | <u>Address</u> |
|------------------------------------|-------------|----------------|
| President or Chairman of Board: | _____ | _____ |
| Member: | _____ | _____ |

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):

| | <u>Total Licensed Beds</u> | <u>Total Title XIX Certified Beds</u> |
|--|----------------------------|---------------------------------------|
| 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:

| <u>Name</u> | <u>Address</u> | <u>Percent of Ownership</u> |
|-------------|----------------|-----------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Election of Medicaid Hospice Benefit

I, _____, elect to receive the Medicaid
(Patient Name/MAID#)

Hospice Benefit from _____ this _____ day of
(Facility Name) (Provider Number)

_____, 19 _____. I am aware that my disease is incurable. I consent to the management of the symptoms of my disease by _____. My family and I will help to develop a plan of care based on our needs. My care will be supervised by my attending physician, _____, and the Hospice Director. My outpatient medications will be provided by _____.

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, in-patient care for acute symptoms, medical procedures ordered by my physician and hospice, and continuous nursing care in the home in acute medical crisis.

I may request volunteer services, when available.

I realize that my family and I have the opportunity for limited respite or relief care in a nursing facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular benefits except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, nurse anesthetist, or dental.

I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand, if I terminate the Medicaid Hospice Benefit, I can resume regular Medicaid if I am still eligible.

I understand that the Hospice Benefit is a home care program. If my family and I choose care not available from the Hospice Agency, I understand that the Hospice and the Medicaid Program are not financially responsible.

I understand that the Hospice Benefit consists of three non-renewable benefits periods – two ninety-day periods, and one thirty-day period. I may be responsible for hospice charges if I exhaust my Medicaid Hospice Benefits, or if I become ineligible for Medicaid services.

I understand that at the end of either the first ninety-day period or the second, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at that time.

I also understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s); I am aware, however, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period I may change the designation of the particular hospice from which hospice care will be received by filing a statement with the hospice from which care has been received and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue for 210 consecutive days.

I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit.

Check one:

I am a Medicare recipient and have elected to use the Medicare Hospice Benefit. My Medicare eligibility for hospice benefits begins _____.

I am not a Medicare recipient.

My Medicare Hospice Benefits have been exhausted as of _____ (Date)

I am currently a long term care facility resident, residing at:

(Facility Name/Address)

Type of Facility:

Skilled Nursing Facility

Intermediate Care Facility

Hospice Benefit Election

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Election

.....
Second Certification Period: (To be signed only if benefits previously revoked or temporarily terminated)

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Second Period

.....
Third Certification Period: (To be signed only if benefit previously revoked or temporarily terminated)

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Third Period

MAP-375 (8/88)

Revocation of Medicaid Hospice Benefits

I, _____ / _____ revoke the hospice benefit allowed
(Patient Name/MAID #)
to me by Medicaid and rendered by _____
(Hospice Agency)
this _____ day of _____, 19____.
(Provider #)

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice care at a later time if this revocation has occurred during either of the two initial 90-day benefit periods.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

Patient's Signature

Witness' Signature

Date

Date

FOR OFFICE USE ONLY

Rationale of Revocation: _____

MAP-376 (8/88)

Change of Hospice Providers

I _____ wish to change the designation of
 (Patient Name/MAID #)
 the particular hospice from which I receive hospice care. I no longer wish to
 receive hospice service from _____, but
 (Provider Name/Number)
 instead wish to receive hospice care from _____,
 (Provider Name/Number)
 effective this _____ day of _____, 19 _____.

I understand that this change of hospice providers is not a revocation of the
 remainder of this election period.

 Patient's Signature or Mark

 Witness' Signature

 Date

 Date

Hospice Patient Status Change

The status of _____ / _____ who has been receiving hospice benefits from _____ since _____ has changed as indicated below.
Patient Name MAID # Hospice Agency Provider # Date of Election

As of _____ Date

- Options for patient status change: Medicare exhausted, eligible for Medicare, resident at facility, changed levels of care, returned to home setting, long term/inactive status, return to active status.

OTHER (Please describe any other change in patient status.)

Signature lines for Patient and Hospice Agency Representative

MAP-378 (8/88)

Termination of Medicaid Hospice Benefits

Hospice benefits for _____ are hereby terminated effective _____, 19____, for the following reason.
(Patient Name/MAID #)

Patient is deceased. Date of death is _____, 19____.

Patient has not requested extension of Medicaid hospice benefits.

Patient has used maximum lifetime hospice benefit days.

OTHER (Please clarify) _____

Condition improved. Patient in Long Term/Inactive Status.

(Hospice Agency) (Provider #)

will continue to follow patient but active hospice benefits are temporarily discontinued. Patient may return to active status any time change in condition necessitates with no loss of remaining benefit periods.

Hospice Agency / Provider #

Hospice Medical Director

Date

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 09/10/86

PROVIDER NAME
PROVIDER NUMBER

RA NUMBER
RA SEQ NUMBER 2

CLAIM TYPE: HOSPICE SERVICES

* PAID CLAIMS *

| INVOICE NUMBER | -RECIPIENT NAME | IDENTIFICATION-NUMBER | INTERNAL CONTROL NO. | CLAIM SVC. DATE | TOTAL CHARGES | CHARGES NOT COVERED | AMT. FROM OTHER SOURCES | CLAIM PMT AMOUNT | EOB |
|----------------|-----------------|-----------------------|----------------------|-----------------|---------------|---------------------|-------------------------|------------------|-----|
| 023104 | DONALDSON R | 3834042135 | 9883324-552-580 | 010186-010186 | 50.00 | 2.00 | 0.00 | 48.00 | 365 |
| 01 PS 3 | PROC 01234 | QTY 5 | | 010286-010286 | 30.00 | 0.00 | | 30.00 | 61 |
| 02 PS 3 | PROC 12345 | QTY 5 | | 010386-010386 | 20.00 | 2.00 | | 18.00 | 365 |

CLAIMS PAID IN THIS CATEGORY: 1

TOTAL BILLED: 50.00

TOTAL PAID: 48.00

AS OF 09/10/86 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER 2 PROVIDER NAME
 RA SEQ NUMBER 2 PROVIDER NUMBER

CLAIM TYPE: HOSPICE SERVICES

* CLAIMS IN PROCESS *

| INVOICE NUMBER | -RECIPIENT NAME | IDENTIFICATION-NUMBER | INTERNAL CONTROL NO. | CLAIM SVC. DATE | TOTAL CHARGES | EOB |
|----------------|-----------------|-----------------------|----------------------|-----------------|---------------|-----|
| 571384 | JOHNSON P | 2471340401 | 9883342-564-210 | 010286-010286 | 32.00 | 260 |
| 574632 | MITCHELL J | 4331740410 | 9883347-575-240 | 010286-010286 | 24.00 | 260 |

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 56.00

AS OF 09/10/86

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

Page 5

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOSPICE SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

061 PAID IN FULL BY MEDICAID
254 THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260 ELIGIBILITY DETERMINATION IS BEING MADE
365 FEE ADJUSTED TO MAXIMUM ALLOWABLE
999 REQUIRED INFORMATION NOT PRESENT

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

ADJUSTMENT REQUEST FORM

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

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

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

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

12. Signature

13. Date

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

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE: _____

PROVIDER NAME: _____ PROVIDER #: _____

RECIPIENT NAME: _____ MAID: _____

BIRTHDATE: _____ ADDRESS: _____

DATE OF SERVICE: _____ TO _____ DATE OF ADMISSION: _____

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

POLICY #: _____ CLAIM NO.: _____

AMOUNT OF EXPECTED BENEFITS: _____

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

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

NOTICE OF AVAILABILITY OF INCOME
FOR LONG TERM CARE/WAIVER
AGENCY/HOSPICE

A. Case Name _____
 Committee Payee
 Case No. _____

B. Initial Change

C. Client's Name _____ Birth Date _____ Title XVIII Title XIX
 (Mo./Yr.)

D. Current Facility/
Waiver Agency/Hospice _____ Address _____

Actual Admission Date to this Facility/Waiver Agency/Hospice _____ Date of Discharge or Date of Death (If Applicable) _____
 SNF ICF ICF/MR
 MH/PSY HCBS
 AIS/MR Hospice

E. Previous Facility/
Waiver Agency/Hospice _____ Address _____

Admission Date _____ Date of Discharge _____ Type: SNF ICF ICF/MR MH/PSY FCH
 PCH HCBS AIS/MR Hospice

F. Family Status

1. Single Married No. of Children _____
 Total Dependents _____

2. Spouse
 Ineligible Eligible Patient Non-Patient

(Co.) (Prg.) (Number)

H. Explain Incurred Medical Expenses

List full names and policy numbers of all health insurance policies.

G. Income Computation

1. Unearned Income
 Source of Unearned Income

| | Amount |
|--|----------|
| a. RSDI (Including SMI if dedct. by SSA) | |
| b. SSI | |
| c. RR (Including SMI, if dedct. by RR) | |
| d. VA | |
| e. State Supplementation | |
| f. Other (Specify) _____ | |
| g. Sub-Total Unearned Inc. (1a thru 1f) | \$ _____ |

2. Earned Income

| | Amount |
|-------------------------------|----------|
| a. Income _____ (Source) | |
| b. Earned Income Deduction(s) | - |
| c. Sub-Total Earned (2a-2b) | \$ _____ |

3. Total Income (1g plus 2c) \$ _____

4. Deductions

| | Amount |
|---|----------|
| a. Incurred Medical Expenses (Exclude Health Ins. of Client) | |
| b. Health Insurance | |
| 1) SMI (JKM Only) | |
| 2) Other Health Ins. | |
| c. Spouse/Family Maintenance | |
| d. Personal Needs Allowance | \$ _____ |
| e. Total Deductions (4a thru 4d) | \$ _____ |

5. Available Income (3 minus 4e) \$ _____

6. Available Income (rounded) \$ _____

I. Status

1. Active Case Yes No

2. If active, Eff. Date for MA _____

3. If discontinued, Eff. Date of MA Disc. _____

4. Program Code Change Yes No
 From _____ To _____ Eff. _____

5. SSI Entitlement Confirmed
 Confirmation Date _____

6. Available Monthly Income (Item G-6) _____
 Effective Date (Change forms only) _____

J. Comment Section

1. LO1 MAP-24 MAP-374
 DMS Letter of Approval
 DMR-001. (Date Received)

2. Corrected MAP-552
 Correction of MAP-552 dated _____

3. Private Pay Patient
 From _____ to _____

4. PAFS-105. . . Date Sent _____

5. Additional comments:

K. _____
 (Signature) (Date)

MAP-383 (11/88)

Other Hospitalization Statement

This is to certify that hospitalization at

_____ Name of Facility

for _____ beginning on
 _____ Recipient Name/MAID Number

_____ is not related to the terminal illness of this
 _____ Date of Admission
 patient.

The reason for this admission is _____ /
 _____ Diagnosis ICD 9 CM Code

This patient's terminal illness is _____ /
 _____ Diagnosis ICD 9 CM Code

Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the Kentucky Medical Assistance Program.

Signed: _____
 _____ Medical Director

_____ Hospice Agency

_____ Date

Please attach documentation verifying that hospitalization is not related to terminal illness.

Is this the first time this patient has been hospitalized for a condition not related to the terminal illness? Yes No

If no, dates of previous admission _____

Diagnosis for previous admission _____
 _____ ICD 9 CM Code

Approved by the KMAP

Denied by the KMAP

_____ KMAP Signature _____ Date

MAP-384 (8/88)

HOSPICE DRUG FORM

| | | | | | | | |
|---|--|--|-------------------------------|---|--------------------------------|---|--|
| 1. Recipient Last Name | | 2. First Name | | | 3. Medical Assistance I.D. No. | | |
| 4. Date Medicaid Hospice Coverage Began | | 5. (1) First Diagnosis (Not Related to Terminal Illness) | | | ICD.9 CM Code | | |
| 6. Total Number of Prescriptions Not Related to Terminal Illness | | (2) Second Diagnosis (Not Related to Terminal Illness) | | | ICD.9 CM Code | | |
| 7. Drug Name Manufacturer/Strength (10 mg, 15 ml, etc.) | | 8. NDC # | 9. Units | 10. Price Per Unit | 11. Total Charge | 12. Medicaid Maximum Allowance (Leave Blank) | |
| | | | | | | | |
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| | | | | | | | |
| 13. Total Units This Invoice | | | 14. Total Charge This Invoice | | | | |
| 15. Terminal Diagnosis | | ICD. 9 CM Code | | 16. Did Patient Require These Prescriptions Prior to Diagnosis or Terminal Illness? ___ YES ___ NO | | | |
| 17. Are These Prescriptions the Result of Hospitalization not Related to Terminal Illness? ___ YES ___ NO | | | | 18. If yes, Dates of Hospitalization: _____ FROM _____ TO _____ | | | |
| 19. Name of Hospital | | | | 20. Prescribing Physician | | | |
| 21. PROVIDER CERTIFICATION AND SIGNATURE: This is to certify that the prescriptions entered above are <u>not</u> related to the terminal illness of this recipient. | | | | | | | |
| Signed _____ | | | | | | | |
| 22. PROVIDER NAME AND ADDRESS | | 23. PROVIDER NUMBER | | 24. INVOICE DATE | | 25. INVOICE NUMBER | |
| | | | | | | | |