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SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medical Assistance Program Primary Care Services 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) 372-2921 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes 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 provided 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. KMAP 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, 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. KMAP 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 provided 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 seventeen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen 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 seven 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 and recipients. 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 is payor of last resort. Accordingly, the provider of service should seek reimbursement from such third party groups for medical services provided. 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.

A provider's adherence to the policies in this manual are monitored through either post-payment review by the Department or by computer audits and edits. When computer audits or edits fail to function properly the policies in this manual remain in effect and thus become subject to post-payment review.

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

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 EDS 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 III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Definition and Intent

1. The Primary Care Services element of the KMAP was developed in recognition of a need for comprehensive ambulatory health care services in a single setting, with the ultimate objective being the improvement of the general health of the recipients served by participating primary care centers. It is expected that this form of patient management will effectively result in a reduction in hospital stays and institutional patient care.
2. On-site care, focusing on the general ongoing health needs of the center's patients with emphasis on preventive and maintenance health measures, is provided by a team of medical and allied health personnel skilled in meeting a variety of family health and health related needs.
3. The center serves as the primary health resource for the patient and his family, arranging for referral to and acceptance of the patient by the appropriate provider when the specific need cannot be met directly by the center. Comprehensiveness and continuity of care are assured by the establishment and periodic updating of a written plan of care for each patient/family served by the center.
4. The primary care center is actively involved with health and health-related concerns of the community and makes health education available to the total community.

SECTION III - CONDITIONS OF PARTICIPATION

B. Participation Requirements

1. To participate as a reimbursable health provider under the primary care services element of the KMAP, each primary care center will be required to meet the standards established for licensure, be licensed by the Certificate of Need and Licensure Board, and meet the additional requirements set forth in State Regulation 907 KAR 1:054.
2. Out-of-State primary care centers applying for participation must be licensed by the appropriate agency of the State in which they are located, if applicable, and in addition must meet the standards set forth by the Kentucky Certificate of Need and Licensure Board and State Regulation 907 KAR 1:054.
3. Medical services rendered eligible Title XIX recipients must be provided by or under the direct supervision of a staff professional who is appropriately licensed by Kentucky or the State in which the center is located. This professional must render only those services which are within the scope of services authorized by the license.
4. The Primary Care Center licensure regulation provides the minimum basis for designation as a primary care center. The Title XIX Program regulation reinforces these licensure requirements, specifies a wider range of services which will be reimbursable for Medicaid eligibles and provides certain limitations with respect to reimbursable services.
5. The Title XIX Program specifications require participating primary care centers to provide a program of basic services which shall include medical, diagnostic and treatment service for all age groups; treatment of injuries and other traumas; prenatal and postnatal care; a program of preventive health

SECTION III - CONDITIONS OF PARTICIPATION

services which must include well-baby care, and immunizations and which may include other types of preventive care; referral services; health education services; and the direct professional services of a dentist, clinical pharmacist and optometrist or a substitution on a one for one basis for any or all of the preceding three services by an identifiable program for providing family planning services, home health services, social service counseling, pharmacy services (may not be used as a substitute if clinical pharmacist is selected as a basic service), nutritional services, or nurse midwifery services. In addition to the basic services, a primary care center may provide other supplemental services such as holding and observation accommodations, any of the alternate basic services indicated above, outreach services and other ambulatory services within the scope of the Medical Assistance Program, except for institutional care.

6. Having met such requirements, a primary care center is required to enter into a participation agreement with the Cabinet and be issued a notification of participation. Such participation agreement may be nullified by the Cabinet with appropriate prior notice if at any time a primary care center fails to meet a condition of participation or licensure.

An application for participation shall include:

- a. The Provider Agreement (MAP-343)
- b. Provider Information Sheet (MAP-344)
- c. Certification of Conditions Met (MAP-346)
- d. Statement of On-Site Services (MAP-231)
- e. Statement of Authorization (MAP-347). Attach a copy of the license of each licensed professional on staff.
- f. Annual cost report as outlined in the Primary Care Reimbursement Manual.

SECTION III - CONDITIONS OF PARTICIPATION

The completed participation documents, signed by the administrator of the center, must be submitted to the Department for Medicaid Services and subsequently approved, prior to receiving reimbursement for services rendered eligible Program recipients. A provider number and the center's interim rate of payment (CAC) will be included with the notification of participation approval by the Department for Medicaid Services.

7. Concurrent with the effective date of participation in the Primary Care Services element of the Program, the Center will cease to submit billings to any other element of the KMAP for services rendered Title XIX recipients.

If the Center currently submits billings to other elements of the KMAP, a letter from the Center administrator will also be required to terminate other KMAP participation agreements.

8. All physicians/dentists/other licensed professionals must have current valid licenses to practice in the state of Kentucky at the time medical services/procedures are performed.
9. The physician/other licensed professional whose KMAP provider number is entered in Block #17 of the MAP-7 as the professional rendering the service must have patient contact for each service billed.
10. Medical Records: Medical records in the primary care center must substantiate the services billed to the KMAP. The medical records must be accurate and appropriate and entered personally or countersigned by the professional who rendered the service. All records must be signed and dated. Stamped signatures are not acceptable.

The results of diagnostic testing, including negative test results, must be indicated in the medical record of the patient. The date of the test shall be the same date for which the KMAP is billed.

SECTION III - CONDITIONS OF PARTICIPATION

Medical records must be maintained for a minimum of five (5) 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 the Cabinet upon request and made available for inspection and/or copying by Cabinet personnel.

11. The Medical records of the patient in the hospital must document through signed or countersigned notes that the billing physician did one or more of the following:
 - a) personally reviewed the patient's medical history;
 - b) performed a physical examination;
 - c) confirmed or revised the diagnosis;
 - d) face-to-face encounter with the patient;
 - e) discharged the patient.

C. 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;

SECTION III - CONDITIONS OF PARTICIPATION

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 thirty (30) 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;
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.

If a provider is terminated from KMAP participation, services after the effective date of termination are not payable.

SECTION III - CONDITIONS OF PARTICIPATION

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 - SERVICES COVERED

IV. SERVICES COVERED

Each Primary Care Center shall provide directly to eligible program recipients on a regular, full-time basis the basic services, and may provide one or more of the supplemental services.

A. Basic Services

1. Medical diagnostic and treatment services for all age groups as provided by a physician or nurse practitioner.
2. Treatment of injuries and minor trauma.
3. Prenatal and postnatal care.
4. A program of preventive health services to include well-baby care and immunizations. It may also include other types of preventive care.
5. Referral services designed to ensure the referral to and acceptance by an appropriate medical resource, when services necessary to the health of the patient are not provided directly by the center.
6. Health education services which must provide, as a minimum, appropriate personnel to present, on request, information on general health care to local school systems, civic organizations and other concerned local groups. Services are to include distribution of written material on pertinent health subjects.
7. The direct professional services of the following:
 - a. Dentist,
 - b. Clinical Pharmacist, and
 - c. Optometrist.

SECTION IV - SERVICES COVERED

8. Any of the following services may substitute on a one for one basis for the services shown in "7." above, when provided directly by the center in the context of an identifiable program by appropriately trained personnel (further requirements are detailed under description of each service).
 - a. Family planning services
 - b. Home health services
 - c. Social services counseling
 - d. Pharmacy services - If clinical pharmacist is selected as a basic service in "7."; pharmacy services may not be used as a substitute for remaining requirements in "7."
 - e. Nutritional services
 - f. Nurse midwifery services
- B. Supplemental Services
 1. Services within the scope of the Medical Assistance Program, excluding institutional care, which are not provided as basic services.
 2. Holding observation accommodations.
 3. Outreach Services - These services must be provided as a package structured to identify health care needs in the service area.

SECTION IV - SERVICES COVERED

C. Non-Covered Services

1. All institutional services
2. Housekeeping, babysitting, and other homemaker services of like nature
3. Services which are not provided in accordance with restrictions imposed by law OR regulation.
4. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment.

NOTE: Limitations and Prior Authorization

1. Limitations in covered services are addressed within the description of each specific category of service.
2. Services requiring prior-authorization are explained within the description of each specific category of service.

Additional questions regarding limitations and/or prior authorizations for specific services should be directed to the Cabinet for Human Resources, Department for Medicaid Services, Division of Policy and Provider Services, Frankfort, Kentucky 40621 or phone (502) 564-6890.

D. Medical

Diagnostic and treatment services (within the scope of their licensure) as provided by a physician and Advanced Registered Nurse Practitioner (ARNP) on the staff of the Primary Care Center.

1. Exclusions from Coverage
 - a. Procedures purely for cosmetic purposes
 - b. Any service not performed in compliance with State and Federal requirements
 - c. Autopsy procedures

SECTION IV - SERVICES COVERED

- d. Telephone contacts
- e. Contacts between primary care center employees and recipients for purposes of obtaining prescriptions or prescription refills when obtaining medication is the only service provided. (This does not include dispensing of prescriptions.)

2. Inpatient Admissions

Program coverage for hospital inpatient care is limited to a maximum of fourteen (14) days per admission. All admissions are subject to approval by the Peer Review Organization and must be within the scope of covered services.

In order to be considered a "covered inpatient admission" by the KMAP, an admission must be primarily for treatment indicated in the management of an acute or chronic illness, injury or impairment, or for obstetrical care. The KMAP can only provide reimbursement for services which are certified as being medically necessary and within the scope of coverage. The KMAP does not cover what is commonly called "Administratively Necessary Days" (A.N.D.) days of hospitalization for reasons other than medical indications, such as awaiting long term care facility placement.

NOTE: If the admission is determined by the KMAP to be a "non-covered" admission, neither the hospital nor the Primary Care Center will be reimbursed by the KMAP for that admission. Those admissions primarily for elective procedures or cosmetic procedures are excluded from coverage by the Program unless medically necessary or indicated.

Hospital admissions for diagnostic procedures can be reimbursed only when there is adequate documentation that the procedures cannot be performed on an outpatient basis. Readmissions are payable only when an acute worsening of an existing condition occurs, or when an entirely new condition develops requiring hospitalization primarily for treatment indicated in the management of acute or chronic illness, injury or impairment or for obstetrical care. Written descriptive verification of the recipient's condition necessitating readmission may be required before such readmission can be considered for payment.

SECTION IV - SERVICES COVERED

All non-emergency hospital admissions must be pre-authorized by PEERVIEW in order for the KMAP to reimburse the admitting hospital. Prior to the proposed admission, a responsible person in the primary care center's office must contact the PEERVIEW office for pre-admission review. PEERVIEW office staff will assign the initial number of days allowed for the type of admission and provide the pre-admission authorization number. The number of days allowed is considered the standard length of stay for the type of admission barring complications. Both the pre-authorization number and the days approved should be given to the hospital during admission procedures. Emergency admissions and deliveries do not require a pre-authorization number. Extensions beyond the initial number of days require no action on the part of the primary care center. This is a process between PEERVIEW and the hospital.

The toll-free phone number for PEERVIEW KMAP pre-admission reviews is 1-800-423-6512. This number is answered Monday through Friday 8:00-5:30 central time and 9:00-6:30 eastern time.

3. Sterilizations

The KMAP will make payment for sterilizations only when the following conditions are met:

- a. The recipient voluntarily requests the procedure and is advised at least thirty days BEFORE the sterilization procedure of the nature of the sterilization procedures to be performed, of the alternative methods of family planning and of the discomforts, risks, and benefits associated with it. Also, the recipient must be advised that his/her consent to be sterilized can be withdrawn at any time and will not effect his/her entitlement to benefits provided by Federal funds.

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- b. The recipient signs a Sterilization Consent Form (MAP-250) and is advised that a decision not to be sterilized will not affect his or her entitlement to benefits under any government assistance program. The Sterilization Consent Form must be signed by the recipient and the person obtaining the consent at least thirty days before the surgery except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. No more than one hundred and eighty (180) days may elapse between the date the consent form is signed and the date on which the procedure is performed.
- c. The recipient is twenty-one (21) years old or older, at the time of signing the consent form.
- d. The recipient must not have been legally declared mentally incompetent unless he or she has been declared competent for purposes which include the ability to consent to sterilization; or must not be institutionalized. The fact that a facility is classified as an SNF, ICF or ICF/MR is not necessarily determinative of whether persons residing therein are "institutionalized." A person residing in an SNF, ICF, or ICF/MR is not considered to be an "institutionalized individual" for the purposes of the regulations unless that person is either: (a) involuntarily confined or detained under a civil or criminal statute in one of those facilities; or (b) confined under some form of a voluntary commitment, and the facility is a mental hospital or a facility for the care and treatment of mental illness.
- e. The physician who performs the procedure must sign and date the form MAP-250 AFTER the sterilization procedure is performed.

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- f. Interpreters must be provided when there are language barriers, and special arrangements must be made for handicapped individuals.
- g. To reduce the chances of sterilizations being chosen under duress, a consent may not be obtained from anyone in labor or childbirth, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.
- h. These regulations apply to medical procedures performed for the purpose of producing sterility.
- i. Reimbursement is not available for hysterectomies performed for sterilization purposes.
- j. ALL applicable spaces of form MAP-250 must be completed and the form must accompany all claims submitted for payment for a sterilization procedure.

In those cases where a sterilization is performed in conjunction with another surgical procedure (e.g., cesarean section, cyst removal) and compliance with Federal regulations governing payment for the sterilization has not been met, EDS can only make payment for the non-sterilization procedures.

Medical documentation must be attached to the back of the MAP-7 claim form when a procedure is billed to the KMAP which could possibly result in sterilization, but because it is unilateral does not result in sterilization.

See Appendix XIII for a copy of the MAP-250 and instructions for completion of the form.

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4. Hysterectomies

Title XIX funds can be expended for hysterectomies that are medically necessary only under the following conditions:

- a. The person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproduction; and
- b. The individual or her representative, if any, has signed and dated the Hysterectomy Consent Form (MAP-251).
- c. This Hysterectomy Consent Form (MAP-251) must accompany all claims submitted for payment for hysterectomies, except in the following situations:
 - (1) The individual was already sterile at the time of the hysterectomy; or
 - (2) The individual required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible.

The physician must certify in writing either the cause of the previous sterility, or that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency. Such documentation must accompany any hysterectomy procedure for which a Hysterectomy Consent form (MAP-251) was not obtained.

- d. If the service was performed in a period of retroactive eligibility, the physician must certify in writing that the individual was previously informed that the procedure would render her incapable of reproducing, or that one of the exempt conditions was met.

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See Appendix XIV for a copy of the MAP-251 and instructions for completion of the form.

5. Abortion, Miscarriages and Induced Premature Births

KRS 205.560 specifies the conditions under which the KMAP can make payment for induced abortions, induced miscarriages and premature births for Title XIX recipients.

The law states in part that Title XIX Program payment cannot be made "where such aid is for the purpose of obtaining an abortion, induced miscarriage or induced premature birth unless in the opinion of a physician such a procedure is necessary for the preservation of the life of the woman seeking such treatment or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child."

The appropriate certification forms (MAP-235 or MAP-236), indicating the procedure used and signed by the physician, must accompany all invoices requesting payment for these services.

See Appendix XVII for copies of the MAP-235 and MAP-236.

6. Gastric Bypass Surgery

Gastric bypass surgery and other such procedures, including the jejunoileal bypass procedure and gastric stapling, are considered possibly cosmetic procedures and therefore are non-payable unless they meet all of the following criteria:

- a. There is documentation that the recipient suffers from other conditions to an extent dangerous to his/her health, e.g. high blood pressure, diabetes, coronary disease, etc.
- b. There is documentation that all other forms of weight loss have been exhausted, with legitimate efforts on the part of the physician and recipient, i.e. dieting, exercise, and medication.

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- c. There is documentation that the sources of weight gain have been identified and subsequently, treatment was attempted in accordance with the diagnosis.
- d. There is documentation that prior to the surgery at least one (1) other physician besides the surgeon has been consulted and has approved of the surgical procedure as a last resort of treatment.
- e. The recipient is at least 100 pounds over the maximum weight of his/her height and weight category as determined by the attending physician.

It is necessary that the above information accompany each claim submitted for these procedures.

7. Consultations

All consultations billed to the KMAP must include physician/patient contact. Consultations without physician/patient contact are not billable services.

Consultations must have resulted from a specific referral request and have written communication between the consulting and referring physicians as to the results of the examination or evaluation of the recipient. This will be monitored through post-payment review.

The name or KMAP provider number of the referring physician must be indicated in Block #8 of the MAP-7 claim form.

8. Chemotherapy Drugs

(The cost of the Chemotherapy drug only, not to include the administration. Procedure codes for the administration of chemotherapy drugs can be found in the CPT-4 book).

PROCEDURE	DESCRIPTION
J9000	Adriamycin, Doxorubicin HCl, 10 mg. vial
J9010	Adriamycin, Doxorubicin HCl, 50 mg. vial

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PROCEDURE	DESCRIPTION
J9020	Asparaginase, Elspar up to 10,000 units
J9040	Blenoxane, Bleomycin Sulfate, 15 units
J9050	Carmustine, Bischlorethyl Nitrosourea, BCNU, 100 mg vial
J9060	Cisplatin, Platinol, 10 mg. vial
J9062	Cisplatin, Platinol, 50 mg. vial
J9070	Cyclophosphamide Cytoxan 10 cc or 100 mgm
J9080	Cyclophosphamide Cytoxan 20 cc or 200 mgm
J9090	Cyclophosphamide Cytoxan 30 cc or 500 mgm
J9091	1.0 Gram Cytoxan
J9092	2.0 Gram Cytoxan
J9093	100 mg. Lyophilized Cytoxan
J9094	200 mg. Lyophilized Cytoxan
J9095	500 mg. Lyophilized Cytoxan
J9096	1.0 Gram Lyophilized Cytoxan
J9097	2.0 Gram Lyophilized Cytoxan
J9100	Cytarabine Hydro-Chloride Arabinosyl Cytosine; Cytosar, 100 mgm
J9110	Cytarabine Hydro-Chloride Arabinosyl Cytosine; Cytosar, 500 mgm
J9120	Dactinomycin, Actinomycin D, Cosmegen, 3cc/0.5 mg.
J9130	Dacarbazine, DTIC, Dome, DIC, 100 mgm
J9140	Dacarbazine, DTIC, Dome, DIC, 200 mgm
J9150	Daunorubicin, Daunomycin; Rubidomycin Cerubinone
J9160	Delautin, ICC, 250 mgm
J9162	Depo-Provera AQ., up to 1000 mgm
J9165	Diethylstilbestrol Diphosphate .25 mg/5 ml.
J9170	Drolban, Dromostanolone, Propionate, 5 mg/10 ml
J9180	Estradurin 40 mg/2 ml
J9181	Etoposide, up to 50 mg.
J9182	Etoposide, up to 100 mg.
J9190	Fluorouacil, 5FU, 500 mgm amp
J9200	Floxuridine FUDR 500 mg.
J9212	Interferon
J9230	Mechlorethamine Nitrogen Mustard; HN 2; Mustargen, 20 cc or 10 mgm

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PROCEDURE	DESCRIPTION
J9240	Medroxyprogesterone Acetate, Depo-Provera, 400 mg/ml
J9250	Methotrexate Sodium MTX 2 cc or 5 mg.
J9260	Methotrexate Sodium MTX 2 cc or 50 mg.
J9270	Mitracin Mitramycin 2500 mcg
J9280	Mutamycin, Mitomycin, 5 mg
J9290	Mutamycin, 20 mg
J9295	Polyestradiol Phosphate 40 mg.
J9310	Stilphostrol 0.25 gm/5 ml
J9320	Steptozotocin
J9340	Thio Tapa Triethylenethosphoramide 15 mgm
J9350	Thytropar, Thyroid Cancer, 10 Unit Vial
J9360	Vinblastine Sulfate Velban 10 cc or 10 mg.
J9370	Vincristine Sulfate, Oncovin 01 mgm.
J9375	Vincristine Sulfate, 2 mg/2 ml (2 ml vial)
J9380	Vincristine Sulfate, Oncovin 5 mgm
J9999	Not Otherwise Classified, Anti-neoplastic Drugs

9. Procedural Coding

The Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) is utilized by the Program for procedural coding purposes to identify medical services rendered eligible recipients. The HCPCS codes consist of three major sections: national codes, local codes, and CPT-4 codes. The national and local codes, applicable to primary care services, can be found under the appropriate service element in this manual. The CPT-4 codes are listed in the CPT-4 Procedure Coding Manual which can be obtained at the following address:

CPT-4th Edition
Order Dept. OP-341-5
American Medical Association
P.O. Box 10946
Chicago, Illinois 60610

Telephone Number: 1-800-621-8335

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Below are procedures listed in the CPT-4 coding book which are NOT covered by the KMAP Primary Care Program.

NON-COVERED PROCEDURE CODES

PROCEDURE CODES	DESCRIPTION
00100-01999	Anesthesia Procedures
11920-11954	Tattooing Procedures
15875	Suction assisted lipectomy, any site(s)
19355	Correction of inverted nipples
54235	Injection of corpora cavernosa with pharmacologic agent(s) (e.g., papaverine, phentolamine, etc.)
55970	Intersex surgery
55980	Intersex surgery
59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant
59400	Total Obstetric Care includes antepartum care, vaginal delivery and postpartum care
69090	Ear piercing
76001	Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g. nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)
76948	Ultrasonic guidance for aspiration of ova, supervision and interpretation only
76949	Complete procedure
78890	Generation of automated data
78891	Complex manipulations and interpretation
78990	Provision of diagnostic radionuclide(s)
88000-88099	Anatomic Pathology Postmortem Examination
89329-89330	Sperm Evaluation

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PROCEDURE CODES	DESCRIPTION
90749	Unlisted Immunization Injections
90780	IV infusiton therapy; up to one hour
90781	Each additional hour
90799	Unlisted Therapeutic Injection
90880-90889	Other Psychiatry Therapy
92314-92326	Contact Lens Services
92330	Ocular Prosthetics, Artificial Eye
92335	Ocular Prosthetics, Artificial Eye
92342	Spectacle Services (Including Prosthesis for Aphakia)
92353	Spectacle Services (Including Prosthesis for Aphakia)
92354	Spectacle Services (Including Prosthesis for Aphakia)
92355	Spectacle Services (Including Prosthesis for Aphakia)
92358	Spectacle Services (Including Prosthesis for Aphakia)
92390-92396	Supply of Materials
92953	Temporary Transcutaneous Pacing
95135	Allergen Immunotherapy
95150	Allergen Immunotherapy
95170	Allergen Immunotherapy
95199	Allergen Immunotherapy
99000-99015	Administrative Services
99024	Administrative Services
99025	Administrative Services
99052	Administrative Services
99054	Administrative Services
99056	Administrative Services
99058	Administrative Services
99070	Administrative Services
99071	Administrative Services
99075	Administrative Services
99078	Administrative Services
99080	Administrative Services
99090	Administrative Services

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PROCEDURE CODES	DESCRIPTION
99100-99140	Qualifying Circumstances for Anesthesia
99154	Daily Hospital management of epidural or subaracunoid drug administration
99155	Medical conference; 25 minutes
99156	Medical conference; 50 minutes

Only services actually performed can be billed for. The procedure code which most accurately and completely describes the service performed is to be selected for billing purposes to the KMAP. The charge made to the KMAP should be the same charge made for comparable services provided to any party or payor.

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10. The following lists laboratory procedures that can be billed by either a licensed physician (M.D.) or Advanced Registered Nurse Practitioner (ARNP) if the primary care center does not have a certified laboratory and technicians on-site and the services are rendered on-site directly by the M.D. or ARNP.

PROCEDURE	CODE NUMBER
Throat Cultures (Screening)	87081; 87082; 87083; 87084; 87085
Smears for Bacteria, Stained	87205
Bleeding Time	85000; 85002
Red Blood Count	85041
Hemoglobin	85018
White Blood Count	85048
Differential	85007; 85009
Complete Blood Count	85021; 85022; 85028; 85031; 85023*, 85024*, 85025*
Hematocrit	85014
Platelet Count	85580; 85585; 85590; 85595
Prothrombin Time	85610; 85612; 85614
Sedimentation Rate	85650; 85651
Glucose (Blood)	82947; 82949; 84948
Blood Urea Nitrogen	84520; 84525; 84540
Uric Acid	84550
Urine Analysis (Chemical and Microscopic)	81000; 82615
Thyroid Profile	84435; 84443; 84437; 84800; 82756; 84479
Glucose Tolerance	82951, W8724, 82952
Electrolytes	80003; 80002
Ova and Parasites	87177
TB Tests	86585; 86580

*These codes are effective for claims with dates of service on or after 12/01/87.

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PROCEDURE	CODE NUMBER
Coccidioidomycosis	86490
Histoplasmosis	86510
Mumps	86540
Brucella	86002
Fine needle aspiration with or without preparation of smear; superficial tissue	88170
Deep tissue with radiological guidance	88171
Evaluation of fine needle aspirate with or without preparation of smears	88172
Duodenal intubation and aspiration: single specimen	89100
Multiple specimens	89105
Gastric intubation and aspiration: diagnostic	89130; 89132; 89136; 89140; 89141
Nasal smears for eosinophils	89190
Sputum, obtaining specimen, aerosol induced technique	89350

The following procedures are payable only when performed by
a Board-Certified pathologist, oncologist or hematologist:

Bone Marrow smear and/or cell block; aspiration only	85095
Smear interpretation only	85097
Aspiration, staining and interpretation	85100
Aspiration and staining only	85101
Bone Marrow needle biopsy	85102
Staining and interpretation	85103
Interpretation only	85105

This policy is subject to post-payment review.

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A Complete Blood Count (CBC) must be used when billing 3 or more of the following tests: 85007 or 85009, 85041, 85018, 85048, or 85014. When three or more components are performed, the CBC must be billed, and no additional component is allowed.

The KMAP does not cover urinalysis, unless it includes a microscopic examination. By definition this code, when billed, indicates that a total urinalysis with microscopic examination has been performed. "Dipstick" urinalyses are NOT reimbursable by KMAP.

A culture and a smear for bacteria may not both be billed the same date of service for the same diagnosis code.

11. Newborn Care

Services for a newborn are to be billed under the mother's name and MAID number for ROUTINE newborn care and for newborn circumcision. Enter "For Baby (Boy or Girl _____)" in the procedure description for any newborn services billed under the mother's name and MAID number. Routine newborn care should be billed only once per 12 month period.

12. Fetal Testing

Fetal testing procedures are limited to any combination of three (3) tests per twelve (12) month period, per recipient. If more than three (3) tests are billed within a twelve (12) month period for the same recipient, medical documentation justifying the necessity will be required.

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13. Limitations on Covered Emergency Room Visits

Payment for I.V.s, venipunctures, and the interpretation of routine procedures (laboratory and radiology tests, E.K.G., etc.) is included in the payment for the emergency room visit; therefore, these procedures should not be billed separately. This policy is subject to post-payment review.

14. Lock-In Recipients

The Lock-In Program was implemented for recipients who have been identified as using physician and/or pharmacy services inappropriately. Utilization review of recipient participation patterns demonstrates exceptional or excessive use of these Program benefits. Recipients in this category are placed in the Lock-In Program to assist them in establishing: (a) a physician-patient relationship, (b) continuity of care, and (c) to safeguard against the dispensing of contraindicated drugs by multiple physicians and pharmacies.

In order to accomplish these goals, all Lock-In recipients are subject to the following limitations in covered services:

- a. Recipients who are selected for Lock-In receive special PINK Medical Assistance Identification cards each month. Physician and/or pharmacy services must be provided by the Lock-In provider only.
- b. Physician and/or pharmacy services rendered by persons other than the Lock-In provider are considered non-covered services except as follows:
 - (1) The recipient requires physician services at an emergency room, in-patient or out-patient hospital, community mental health, family planning, etc.

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- (2) The recipient requires treatment due to an acute illness, arising after hours, weekends, holidays. Claims will be considered if documentation is provided that indicates the medical necessity of the service (i.e., Lock-In provider not available, injury/accident, recipient out of town).
 - (3) The recipient's Lock-In provider determines that the services of a consultant OR specialist are medically necessary. This includes second opinions for surgery, etc. Claims will be considered for payment if the name and number of the Lock-In provider are entered in Block #8 of the MAP-7 claim form.
- c. The recipient will remain on the Lock-In Program until payment profiles indicate that the recipient's utilization pattern is within acceptable parameters. The recipient is not permitted to change Lock-In providers unless:
- (1) The recipient or provider moves;
 - (2) The provider requests a change; or
 - (3) Sufficient evidence is provided to indicate that a change is in the best interest of the recipient.

Physicians are encouraged to notify the Department for Medicaid Services regarding specific cases of apparent inappropriate utilization of Program benefits. Recipient utilization profiles are then developed for consideration of recipient inclusion in the Lock-In Program.

15. 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

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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.

Primary physician specialists or groups who may participate as primary physicians are:

General Practitioners	Obstetricians	Primary Physician Clinics
Family Practitioners	Gynecologists	Primary Care Centers
Pediatricians	Internists	Rural Health Clinics

Recipients may select a primary physician/clinic who agrees to participate in Medicaid and KenPAC. Recipients not selecting a primary physician will be assigned one within their home county. A primary physician may serve up to 1,500 KenPAC patients. Provider clinics may serve up to 1,500 patients for each full-time equivalent physician. Primary Care Centers and Rural Health Clinics may also be assigned recipients based on the number of Advanced Registered Nurse Practitioners (ARNP) they have on staff.

KenPAC primary physicians/clinics must arrange for physician coverage 24 hours per day, seven days per week. A single 24 hour access telephone number must be provided by the primary physician/clinic. This number will be printed on the recipient's KenPAC Medical Assistance Identification Card.

The following service categories must be provided either by the primary physician/clinic or referred by the primary physician/clinic in order to be reimbursed by KMAP.

Physician (excludes Ophthalmologists and Psychiatrists)
Hospital (Inpatient)(Excludes psychiatric and obstetrical admissions)
Hospital (Outpatient)

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Laboratory Services
Nurse Anesthetists
Rural Health Clinic Services
Home Health Services
Primary Care Centers
Ambulatory Surgical Centers

Services not included in the above list may be obtained by the KenPAC recipient in the usual manner. These services are as follows:

Dental	Early Periodic Screening
Pharmacy	Diagnosis & Treatment
Family Planning	Obstetrical Care and Routine
Hearing and Vision	Newborn Care

Referrals may be made by the KenPAC primary physician/clinic to another provider for specialty care or for primary care during his/her absence. No special authorization or referral form is required, and referrals should occur in accordance with accepted practices in the medical community. However, to ensure that payment will be made, the primary physician/clinic must provide the specialist or other physician with his/her KMAP vendor number, which is to be entered on the billing form to signify that the service has been authorized. Claims for services provided to KenPAC recipients which do not have a referral from their primary physician will not be paid by KMAP.

"Emergency Care" is defined as a condition for which a delay in treatment may result in death or permanent impairment of health.

Pre-authorization from the primary physician is not required for emergency care. However, the primary physician should be contacted, whenever practical, to be advised that care has been provided, and to obtain the physician's authorization number. If the authorization cannot be obtained from the primary physician, the provider must contact the Medicaid Program to obtain an authorization number before submitting a claim.

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"Urgent care" is defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for a normally scheduled appointment (e.g., suturing minor cuts, setting simple broken bones, treating dislocated bones, and treating conditions characterized by abnormally high temperatures).

The primary physician must be contacted for prior authorization of urgent care. If prior authorization is refused, any service provided to the client is not payable by the Kentucky Medical Assistance Program. If the recipient's primary physician cannot be reached for prior authorization, urgent care is to be provided and the necessary authorization secured after service is rendered. Under this circumstance, if post-authorization is refused by the primary physician or the primary physician cannot be contacted after service has been provided, special authorization can be obtained from the Medicaid Program. When the Program determines that the special authorization procedure is being misused, the individual provider will be advised that special authorization for further services may be refused.

Routine care in the emergency room is not to be authorized by the primary physician, and will not be payable under the Program.

KenPAC primary physicians and clinics, in addition to their normal fee for service reimbursements from Medicaid, will be paid \$3.00 per month for each KenPAC patient they manage. Maximum monthly reimbursement may not exceed \$3,000.00 per physician.

Any questions about the KenPAC Program may be referred to:

Manager, KenPAC Branch
Division of Policy and Provider Services
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

Information may be obtained by calling toll free 1-800-635-2570 (In-State) or 1-502-564-5198 (In- or Out-of-State).

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E. Laboratory

Laboratory services covered by the Primary Care Services element of the KMAP are limited to those procedures provided directly by the center, or if purchased, to those services covered under the independent laboratory element of the Medical Assistance Program for each participating Medicare-certified lab. The cost to the center for these services cannot exceed fees established under the KMAP.

Laboratory services must be ordered and prescribed in writing, and signed by a duly licensed staff physician, nurse practitioner or dentist, within the scope of their licensure, for the care and treatment indicated in the management of illness, injury, impairment, maternity care, or for the purpose of determining the existence of an illness or condition in a recipient. The order must be maintained within the Center's records, including the patient's file.

Laboratory tests can not be billed to EDS for services rendered to residents of skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded and developmentally disabled, when the resident is in vendor status with the KMAP.

Procedural Coding

The coding for Laboratory procedures is found in the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS). Effective with services as of July 1, 1988, independent laboratory coverage was expanded to include most laboratory services that each Medicare-certified laboratory can provide. Post-mortem laboratory services are not covered.

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F. Dental

Dental services are limited to those procedures covered through the Dental Services element of the KMAP. Dental services are covered for those Medicaid-eligible recipients who have not yet reached their twenty-first birthday (coverage for those turning 21 will continue through the end of their birth month). Some services are covered for Medicaid-eligible recipients aged 21 and over as well. These dental services are so designated. All services rendered to KMAP recipients must be completed prior to billing the Program for that service. This policy will be monitored through post payment review.

1. Out-of-Hospital Services: Payment for services is limited to those procedures listed on the department's dental benefit schedule, and include benefits in the following categories:
 - a. Diagnostic
 - b. Preventive
 - c. Oral Surgery
 - d. Endodontics
 - e. Operative
 - f. Crown
 - g. Prosthetics
 - h. Orthodontics
 - i. Other Services

Out-of-Hospital refers to all locations where dental services are provided, except hospital admittance. For example:

Clinic
Hospital Outpatient Department
Dentist's Office
Nursing Home
Patient's Home

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2. Out-of-Office Services: Considered to be locations where the dentist must travel away from his usual office to render professional services. For example:

Nursing Home
Patient's Home
Hospital Outpatient Department

Services listed on the Dental Procedural Coding/Benefit Schedule are applicable when rendered in out-of-office locations.

3. In-Hospital Services: Refer to dental services rendered a patient admitted to a hospital overnight. Reimbursement for inpatient dental procedures will be made to both general dentists and oral surgeons.

A general dentist may submit a claim for hospital inpatient service for the patient termed "medically high risk." Medically high risk is defined as a patient with one of the following diagnoses:

Heart Disease
Respiratory Disease
Chronic Bleeder
Uncontrollable Patient - retardate or emotionally disturbed
Other - automobile accident, high temperature, massive infection

All non-emergency hospital admissions must be pre-authorized by the PEERVIEW.

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To obtain prior authorization, a responsible person in the primary care center's office must contact the Peerview office at 1-800-423-6512, for a pre-admission review of proposed elective admissions. A pre-authorization code will be given to the primary care center's office by Peerview, indicating approval for the admission. A person in the primary care center's office must transmit that code to the hospital's admitting office at the time of the admission. This code allows the Peerview coordinator to certify the admission. Kentucky hospitals will not be reimbursed by the KMAP for non-emergency admissions unless the admissions were pre-authorized and certified by Peerview.

4. Procedural Coding/Benefit Schedule

The following list contains all dental services payable by the KMAP. If a service is not listed, it is not payable by the Program. Please make note of services covered for all ages and services limited to ages under 21. Services limited to ages under 21 may be billed for Medicaid-eligible recipients who have not reached their twenty-first birthday. Limitations as to the number of times a service is payable within a calendar year are indicated by procedure code.

NOTE: See Appendix XVI - Definitions of Dental Procedures

DIAGNOSTIC SERVICES (Available to all ages)

Procedure D0270 - Bitewing - Single Film

Procedure D0272 - Bitewing - Two Films

Procedure D0273 - Bitewing - Three Films

Procedure D0274 - Bitewing - Each Additional Film
Limit: A total of four (4) X-rays per patient, per 12 month period, per provider. Each of the above codes should be for one unit of service only.

Procedure D0220 - Intraoral - Periapical Single, First Film

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Procedure D0230 - Intraoral - Periapical Each Additional Film
Limit: A total of fourteen (14) X-rays per patient, per 12
12 month period, per provider

Procedure D0330 - Panoramic - Maxilla and Mandible Film
Limit: One (1) per patient, per every
twenty-four (24) month period, per provider

PREVENTIVE SERVICES (Available to all ages)

Procedure D1110 - Prophylaxis - Adult (Excludes Fluoride)
Note: Adult is defined as age 17 and over

Procedure D1201 - Topical Application of Fluoride (Including
Prophylaxis) Children
Note: Child is defined as 16 and under

Procedure D1202 - Topical Application of Fluoride (Including
Prophylaxis)
Note: Includes recipients age 17-20

Limit: One (1) per 12 month period, per patient

ORAL SURGERY (Available to all ages)

Procedure D7110 - Extraction, Single Tooth
Limit: One per tooth, per patient

Procedure D7120 - Extraction, Each Additional Tooth
Limit: One per tooth, per patient

Procedure D7130 - Root Removal - Exposed Roots
Note: Root removal is not payable on same
date of service to same tooth as the tooth's
extraction.

IMPACTIONS

Procedure D7210 - Surgical removal of erupted tooth, requires elevation

Procedure D7211 - Surgical removal of erupted teeth, each additional

SECTION IV - SERVICES COVERED

IMPACTIONS (Continued)

- Procedure D7220 - Impaction that requires incision of overlying soft tissue and removal of tooth
- Procedure D7221 - Surgical removal, soft tissue impaction, each additional
- Procedure D7230 - Impaction that requires incision of overlying soft tissue, elevation of a flap, and either removal of bone and tooth or sectioning and removal of tooth
- Procedure D7231 - Surgical removal, partial bony impaction, each additional
- Procedure D7240 - Impaction that requires incision of overlying soft tissue, elevation of flap, removal of bone and sectioning of the tooth for removal
- Procedure D7241 - Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances
- Procedure D7242 - Surgical removal, complete bony impaction, single each
- Procedure D7243 - Surgical removal, complete bony impaction each additional
- Procedure D7250 - Root recovery (Surgical removal of residual root)
- Procedure D7260 - Oroantral fistula closure (and/or antral root recovery)

NOTE: Extractions performed by general dentists in the outpatient department of the hospital are not reimbursable by the KMAP except in cases determined to be medically necessary and appropriate oral surgical care is unavailable. Documentation will be required prior to any payment consideration. It would be necessary for the dentist to attach a letter of explanation to the claim form. This letter would need to include the diagnosis necessitating hospital care and also a statement that an oral surgeon was not available in the medical service area. This letter must be signed by the dentist; delegated signatures are not acceptable. When appropriate oral surgical care is available, recipients should be referred to a participating oral surgeon who can perform this service in his office.

SECTION IV - SERVICES COVERED

When the patient has already been admitted to the outpatient department for other dental services, i.e., fillings, root canals, etc., in addition to the extractions, the provider can be reimbursed for the extractions. However, a letter signed by the dentist must be attached to the claim explaining the circumstances of the admission. Pedodontists are excluded from the requirements concerning outpatient department extractions. This policy is monitored through post-payment review.

ENDODONTIC SERVICES (Limited to recipients under age 21)

Procedure D3110 - Pulp Cap - Direct (Excluding Final Restoration)

NOTE: Direct pulp cap is defined as the application of a pulp capping material such as calcium hydroxide is placed directly on or in contact with the vital pulp tissue. Placement of the material over an area in close proximity of the cap but not actually in contact with the pulp chamber does not constitute a direct pulp cap.

Procedure D3220 - Vital Pulpotomy (Excludes Final Restoration)

Procedure D3310 - Root Canal Therapy, Anterior (Excludes Final Restoration)

Procedure D3320 - Root Canal Therapy, Premolar (Excludes Final Restoration)

Procedure D3330 - Root Canal Therapy, Molar (Excludes Final Restoration)

NOTE: The Sargenti method of root canal treatment is not covered under the present root canal procedure codes. When billing for root canal therapy, the procedure constitutes treatment of the entire tooth. It is not appropriate to perform a root canal on only one root of a molar and bill the KMAP for root canal therapy on a molar since that code represents treatment to the entire tooth. These are monitored through post-payment review.

SECTION IV - SERVICES COVERED

OPERATIVE SERVICES (Available to all ages)

AMALGAM - PRIMARY

- Procedure D2110 - Amalgam - One Surface
- Procedure D2120 - Amalgam - Two Surfaces
- Procedure D2130 - Amalgam - Three Surfaces
- Procedure D2131 - Amalgam - Four Surfaces

AMALGAM - PERMANENT

- Procedure D2140 - Amalgam - One Surface
- Procedure D2150 - Amalgam - Two Surfaces
- Procedure D2160 - Amalgam - Three Surfaces
- Procedure D2161 - Amalgam - Four or More Surfaces

COMPOSITE RESIN

- Procedure D2210 - Silicate Cement per Restoration
- Procedure D2310 - Acrylic or Plastic or Composite Resin
- Procedure D2330 - Composite Resin - One Surface
- Procedure D2331 - Composite Resin - Two Surfaces
- Procedure D2332 - Composite Resin - Three Surfaces
- Procedure D2335 - Acrylic or Plastic or Composite Resin
(Involving Incisal Angle or Four or More Surfaces)

NOTE: This procedure code can not be billed in conjunction with any other operative service code or the procedure code for crowns performed on the same tooth on the same date of service. The use of mastiques is not allowed for this procedure code. Policy is monitored through post-payment review.

SECTION IV - SERVICES COVERED

Limit: Acrylic, Plastic or Composite Resin Fillings (procedure codes D2310-D2335) are limited to anterior teeth only. Anterior teeth are defined as tooth numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R.

NOTE: The KMAP recognizes five (5) surfaces of a tooth (buccal or labial, mesial, distal, lingual, occlusal or incisal). Any combination of the above procedure codes can be used for a total of 5 surfaces, per tooth, per provider, per date of service. This is monitored by both computer audits and post-payment review.

CROWN (Limited to recipients under age 21)

Procedure D2930 - Prefabricated Stainless Steel Crown -
Primary Tooth

Procedure D2931 - Prefabricated Stainless Steel Crown -
Permanent Tooth

Procedure D2932 - Prefabricated Resin Crown -
Limit: Anterior Teeth Only

NOTE: Should a provider choose to provide crowns for anterior teeth and/or permanent teeth, the usual and customary charge for a stainless crown must be billed. Since reimbursement for the tooth's restoration is included in the payment for the crown, this procedure cannot be billed in conjunction with any other operative service code for the same tooth number. This policy is reviewed by both system audits and post-payment review.

PROSTHETIC SERVICES (Limited to recipients under age 21)

Procedure W0716 - Transitional appliance, includes one tooth on
appliance, upper appliance
Limit: One per 12 month period, per patient

Procedure W0718 - Transitional appliance, includes one tooth on
appliance, lower appliance
Limit: One per 12 month period, per patient

SECTION IV - SERVICES COVERED

- Procedure W0725 - Repair of fracture of transitional appliance and space maintainer
Limit: Three per 12 month period, per patient
- Procedure W0726 - Repair of fracture and replacement of one broken tooth on a transitional appliance and space maintainer
Limit: Three per 12 month period, per patient
- Procedure D5610 - Repair broken complete or partial denture - No teeth damage
Limit: Three per 12 month period, per patient
- Procedure D5620 - Repair broken complete or partial denture - Replace one broken tooth
Limit: Three per 12 month period, per patient
- Procedure D5640 - Replace broken tooth on denture. No other repairs.
- Procedure D5630 - Replace additional teeth - each tooth
- Procedure D5750 - Relining upper or lower complete denture (laboratory)
Limit: One per 12 month period, per denture, per patient

Note: The repair of the clasp on removable partial dentures, and relining of removable partial dentures are not presently covered benefits.

ORTHODONTIC SERVICES (Limited to recipients under age 21)

Limit: To any combination of the below procedures per 12 month period totaling two, per patient

- Procedure D1510 - Space maintainer, fixed unilateral type
- Procedure D1515 - Space maintainer, fixed bilateral type
- Procedure D1520 - Space maintainer, removable unilateral type

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Procedure D1525 - Space maintainer, removable bilateral type

Procedure D8110 - Removable Appliance Therapy

Procedure D8120 - Fixed or cemented appliance therapy

NOTE: Tooth numbers are no longer required for orthodontic services. See Appendix XVI - Definitions of Dental Procedures

OTHER SERVICES

Procedure D9110 - Palliative (emergency) treatment of dental pain, minor procedures
Limit: One per date of service, per recipient, per dentist

NOTE: Emergency Treatment refers to an actual dental treatment, necessary in an emergency situation, that is not covered by any other procedure on the Dental Benefit Schedule. Only one emergency may exist during any one visit, even though treatment may involve more than one procedure or tooth. It is necessary that both the diagnosis and the actual treatment rendered be entered on each claim form submitted for procedure D9110.

When the emergency treatment is a covered procedure, or a non-emergency, non-covered treatment, the emergency treatment procedure may not be billed. The following list represents unacceptable and therefore non-payable services for procedure D9110.

1. Routine office calls
2. Oral exams
3. Referrals to other dentists or physicians
4. Pins for retention of fillings
5. Saline irrigations
6. Full mouth deep scaling and curretage unless to relieve acute periodental pain

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7. Wires revised
8. Dressing changes unless for dry socket
9. Panorex interpretation
10. When D5750 is done on same day as a denture related D9110
11. When D7110 or D7120 are done on same day to same tooth
12. Gingeectomy
13. Appliance removal or removal of braces
14. Frenunectomy
15. Bone Trim with extractions
16. Adjust appliance or retainer
17. Papilloma removal
18. Sutures with extractions
19. Suture removal
20. When D2110 through D2332 are done on same day to same tooth
21. Dispensing drugs
22. Telephone contacts

SECTION IV - SERVICES COVERED

DENTAL BENEFIT SCHEDULE FOR ORAL SURGEONS (Available to All Ages)

The following list contains all procedures payable to oral surgeons under the KMAP Dental Services Program. All other oral surgical procedures, including x-rays, are referenced in the CPT-4 coding book.

Limit: One extraction per tooth, per patient.

SIMPLE EXTRACTIONS

- Procedure D7110 - Extraction, Single Tooth
- Procedure D7120 - Extraction, Each Additional Tooth
- Procedure D7130 - Root Removal - Exposed Root

NOTE: Root removal is not payable on the same date of service to the same tooth as the tooth's extraction.

IMPACTIONS

- Procedure D7210 - Surgical removal of erupted tooth, requires elevation
- Procedure D7211 - Surgical removal of erupted teeth, each additional
- Procedure D7220 - Impaction that requires incision of overlying soft tissue and removal of tooth
- Procedure D7221 - Surgical removal, soft tissue impaction, each additional
- Procedure D7230 - Impaction that requires incision of overlying soft tissue, elevation of a flap, and either removal of bone and tooth or sectioning and removal of tooth
- Procedure D7231 - Surgical removal, partial bony impaction, each additional
- Procedure D7240 - Impaction that requires incision of overlying soft tissue, elevation of flap, removal of bone and sectioning of the tooth for removal
- Procedure D7241 - Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances
- Procedure D7242 - Surgical removal, complete bony impaction, single each
- Procedure D7243 - Surgical removal, complete bony impaction each additional
- Procedure D7250 - Root recovery (Surgical removal of residual root)
- Procedure D7260 - Oroantral fistula closure (and/or antral root recovery)

Questions regarding oral surgical procedures should be directed to the Division of Policy and Provider Services at (502) 564-6890.

SECTION IV - SERVICES COVERED

G. Family Planning

1. Initial Visit

a. Complete Medical History--A complete medical history shall be obtained and recorded and shall include, but not be limited to:

- 1) Complete obstetrical history, with menarche and menstrual history, last menstrual period, gravidity, parity, pregnancy outcomes, and complications of any pregnancy and/or delivery.
- 2) Any significant illnesses, hospitalizations, and previous medical care and the indicated systems review, e.g., cardiovascular, renal, neurologic, hepatic, endocrine, hematologic, gynecologic (Dysmenorrhea, metrorrhagia, menorrhagia, post-coital bleeding, vaginal discharge, dyspareunia) and venereal disease.
- 3) Previous contraceptive devices or techniques used, and problems related to their use.
- 4) Present and past physical conditions which might influence choice of contraceptive method, to include:
 - a) Thromboembolic disease
 - b) Hepato-renal disease
 - c) Breast and/or genital problems
 - d) Diabetic and pre-diabetic conditions
 - e) Cephalgia and migraine
 - f) Hematologic phenomena
 - g) Pelvic inflammatory disease

SECTION IV - SERVICES COVERED

- 5) Relevant family health history, including significant recurrent chronic illness, genetic aberrations, and unusual health factors among family members.
 - 6) Relevant psychiatric history, including previous history of mental depression.
 - 7) Social history.
- b. Physical Examination--The initial examination shall include:
- 1) Thyroid palpation
 - 2) Inspection and palpation of breasts and axillary glands, with instructions to the patient for self-examination
 - 3) Auscultation of heart
 - 4) Auscultation of lungs if respiratory symptoms present
 - 5) Blood pressure
 - 6) Weight and height
 - 7) Abdominal examination
 - 8) Pelvic examination, including speculum, bimanual, and rectovaginal examinations
 - 9) Extremities
 - 10) Others as indicated

SECTION IV - SERVICES COVERED

- c. LABORATORY AND CLINICAL TESTS--The recipient shall receive at least the following laboratory and clinical tests.
- 1) Hematocrit or hemoglobin
 - 2) Urinalysis for sugar and protein
 - 3) Papanicolaou smears
 - 4) Culture for N gonorrhoea
 - 5) Serology for syphilis*
- d. INFORMATION AND EDUCATION REGARDING CONTRACEPTIVE METHODS--
The recipient shall be given comprehensive, detailed information concerning reversible and irreversible contraceptive methods available. This information shall include mode of action, advantages and disadvantages, effectiveness, and common side effects of each method. Basic information concerning venereal disease shall also be given.
- At the outset of the discussion, the recipient's level of knowledge regarding reproductive functions shall be established and basic information presented where necessary.
- Ample time shall be given for the recipient to ask pertinent questions and to relate the presented information to his/her personal situation.

*ONLY WHEN MEDICALLY INDICATED

SECTION IV - SERVICES COVERED

- e. PRESCRIPTION OF CONTRACEPTIVE METHOD--The physician shall prescribe the contraceptive method, based on the medical and psychiatric history, the medical examination, laboratory tests, and the recipient's wishes. The physician or the registered nurse shall give complete verbal instructions as to use of the method, and the recipient shall also be given complete written instructions.

ARNP limitations will be based on the written protocols as they relate to the specific contraceptive method.

ALL OF THE PRECEDING SERVICES MUST BE COMPLETED AND DOCUMENTED BEFORE BILLING FOR AN INITIAL EXAMINATION. Each client is limited to one initial visit per provider per lifetime.

2. Revisits by Contraceptive Patients

Subsequent visits to the clinic shall be scheduled at least annually and in accordance with the contraceptive method prescribed.

- a. ORAL CONTRACEPTIVE RECIPIENTS shall return to the clinic not later than three months after the initial prescription is issued, and thereafter as indicated, or at least annually.

During the first scheduled follow-up visit, at least the following services shall be provided:

- 1) An interim history, to include pain (especially in the arms and chest), headaches and visual problems, mood changes, leg complaints, vaginal bleeding and/or discharge, and VD history
- 2) Review of menstrual history
- 3) Blood pressure, weight check
- 4) Laboratory tests as indicated

SECTION IV - SERVICES COVERED

- b. I.U.D. RECIPIENTS shall return to the clinic not later than three months following insertion of the device, at which time the following services shall be provided:
 - 1) A repeat pelvic examination with visual inspection of the cervix
 - 2) Blood pressure and weight
 - 3) Menstrual history review
 - 4) Review of abdominal symptoms, fever, vaginal bleeding/discharge
 - 5) Laboratory tests as indicated
- c. DIAPHRAGM RECIPIENTS shall be seen within two to four weeks after initial fitting, to assure that the recipient can insert, position, and remove the diaphragm correctly.
- d. RHYTHM METHOD--Recipients using the rhythm method shall be seen in one month after initial visit, for instruction and assessing complaints, and six months thereafter, for review of menstrual calendar and temperature charts.
- e. OTHER--Recipients using other methods of contraception do not require a routine follow-up visit for medical review or examination prior to the required annual visit.

3. Annual Visits

Annual visits are required for all contraceptive recipients. During these visits, at least the following services shall be provided:

- a. Interim health history to update all medical and psychiatric information required in the initial history.
- b. Complete physical examination, by the physician or ARNP, including all procedures required during the initial physical exam.

SECTION IV - SERVICES COVERED

- c. Repeat of initial laboratory and clinical procedures detailed in Section 1.c., page 3.
- d. Evaluation of use of current method of contraceptive and change in prescription when indicated. Any change shall be based on interim medical and psychiatric history, physical examination and laboratory tests, and the recipient's satisfaction and success with the current method.
- e. Complete verbal and written instructions if prescription is changed.

Annual visits are limited to one per nine months.

6. Sterilization Counseling

Counseling services involving transmittal of complete information regarding male and/or female sterilization procedures shall be provided the individual or couple requesting such services, plus full information concerning alternate methods of contraception. These counseling services shall be provided by the physician, the advanced registered nurse practitioner and shall meet at least the following conditions:

- a. The recipient's level of knowledge regarding reproductive functions shall be assessed, and proper instruction given where needed.
- b. A full discussion of reversible contraceptive methods shall be given.
- c. The recipient shall be made fully aware that the sterilization procedure will most likely be irreversible.
- d. Sterilization procedures shall be explained in detail, with use of charts or body models.
- e. The recipient shall be given complete information concerning possible complications and failures.
- f. The relative merits of male versus female sterilization shall be discussed with both partners, if both are available.
- g. The recipient shall be given information relating to the fact that sterilization does not interfere with sexual function or pleasure.
- h. The function of the counselor is to provide information, and he/she shall in no way seek to influence the recipient to be sterilized.

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The following conditions shall be considered contraindications for voluntary sterilization:

- a. The recipient has physical, mental, or emotional conditions which could be improved by other treatment.
- b. The recipient is suffering from temporary economic difficulties which may improve.
- c. The recipient or couple feel that they are not yet ready to assume the responsibilities of parenthood.
- d. The recipient expresses possible wish to reverse the procedure in case of a change of circumstances.

If sterilization is not desired, alternate methods of contraception shall be discussed.

See Section IV, pages 4.5 and 4.6 for requirements related to sterilization procedures.

7. Infertility Services

Provision shall be made for screening and diagnosis of fertility problems. Recipients requesting infertility services shall receive complete physical exam and history, shall be given full information concerning reproductive functions, available tests and possible remedial procedures, and shall be referred to and accepted by a medical provider who can make available at least the following services:

- a. Complete history and physical examinations of both partners.
- b. G.C. and serologic testing of both partners.
- c. Basal body temperature monitoring.
- d. Semen analysis.
- e. Cervical mucus examination.
- f. Vaginal smear for assessment of estrogen production.
- g. Endometrial biopsy.
- h. Hysterosalpingogram.

SECTION IV - SERVICES COVERED

8. Vaginal Infections

The clinic shall be responsible for diagnosis and treatment or referral of recipients suffering from vaginal infections.

9. Emergency Services

Provision shall be made for handling emergencies related to contraceptive services when the clinic is not in session.

10. Pregnancy Testing

The clinic shall provide pregnancy testing on request by the recipient, when indicated by the history or physical examination, or when the prescribed method of contraception would indicate need for same.

11. Referrals

The clinic shall be responsible for referral to the proper resource in the following circumstances, and for ensuring that the recipient is accepted by the resource to which he/she is referred.

- a. Medical problems indicated by history, physical examination, or laboratory or clinical test.
- b. For pregnancy related services when appropriate.
- c. For social case work not appropriately handled by agency personnel.
- d. For abortion counseling.

SECTION IV - SERVICES COVERED

12. Supplies

The family planning agency shall make available to the recipient, on a continuing basis where applicable, at least the following contraceptive supplies:

- a. Oral contraceptives
- b. Intrauterine devices
- c. Diaphragms
- d. Foams
- e. Thermometers for rhythm method
- f. Jellies and Creams
- g. Condoms

13. Medical Records

The family planning agency shall maintain complete recipient medical records, which shall contain but not be limited to the following:

- a. Initial and interim histories -- medical, psychiatric, and social.
- b. Record of initial and interim physical examinations.
- c. All laboratory reports.
- d. Description of each visit, to include services provided, supplies dispensed, and progress notes (recipient response to service or to contraceptive method).
- e. Record of all referrals made, to include reason for referral, source to whom recipient was referred, and any information obtained as a result of referral.
- f. Record of any follow-up by outreach or other agency staff outside clinic setting.

SECTION IV - SERVICES COVERED

14. Availability of Services

Services of the family planning agency shall be available to each and every person requesting same, regardless of sex, race, age, income, number of children, marital status, citizenship or motive.

HCPCS Local Family Planning Services
Procedure/Supply Codes

Type of Contraceptive Dispensed - This Visit	Intake or Initial Visit	Physician/Advanced Registered Nurse Practitioner				Registered Nurse		LPN
		Medical Revisit or Follow-up Visit With Pelvic Ex- amination	Medical Revisit or Follow-up Visit Without Pelvic Exam.	Supply and Coun- seling Visit	Annual Revisit and Ex- amination	Supply and Coun- seling Visit	Supply Only	Supply and Coun- seling Visit
Birth Control Pills	X1110	X1210	X1310	X1410	X1510	X2410		
Intrauterine Device	X1120	X1220	X1320	X1420	X1520	--	--	--
Diaphragm	X1130	X1230	X1330	X1430	X1530	--	--	--
Foam/Condoms	X1140	X1240	X1340	X1440	X1540	X2440	X0024	X3440
Rhythm	X1150	X1250	X1350	X1450	X1550	X2450	X0025	X3450
Injection	X1170	X1270	X1370	X1470	X1570	--	--	--
Referral for Sterilization	X1180	X1280	X1380	X1480	X1580	X2480	--	--
Other(Specify)	X1190	X1290	X1390	X1490	X1590	X2490	X0029	X3490
None Dispensed This Visit	X1100	X1200	X1300	X1400	X1500	X2400	--	X3400

SECTION IV - SERVICES COVERED

H. Pharmacy

Pharmacy services must meet the standards of the pharmacy component of the KMAP. A pharmacy component of the Primary Care Center must hold an operation permit from the Board of Pharmacy in the state in which the Center is located.

1. Providers must maintain such records as are necessary to fully disclose the extent of the service provided, including the original prescription and its refills. The original prescription must be maintained in a numerical order prescription file. If computerized prescription records are maintained, adherence to the requirements of Kentucky Board of Pharmacy Regulation 201 KAR 2:170 is acceptable for prescriptions for which Kentucky Medical Assistance Program payment is requested and made. Records must be maintained as a prescription file independent of recipients' case records for a period of not less than five (5) years from date of service. Providers must furnish to the Department or its authorized representatives, as requested, information regarding any claims for pharmacy services rendered under the Medical Assistance Program.
2. Notification must be made to the KMAP regarding any change in the status of the pharmacy component.
3. The cost of covered drug items which are prescribed and certified to be required for eligible Program recipients by a duly-licensed physician, dentist, osteopath, podiatrist, or optometrist will be allowed under conditions established in the Primary Care Principles of Reimbursement. "Duly-licensed physician, dentist, osteopath, podiatrist, or optometrist" would refer to those individuals so licensed under the existing state regulations and statutes effective in the state wherein they practice.
4. In addition to standard drug pre-authorization, there are certain drugs which may be considered generally suitable for individuals in specific living circumstances and/or with a characteristic pattern of health needs (e.g. personal care home recipients). In these circumstances, groups of drugs may be pre-authorized for individuals upon appropriate request, with no individual pre-authorization numbers assigned for the drugs.

SECTION IV - SERVICES COVERED

The drugs which under these circumstances may be approved as a group, will be outlined in a separate section of the Quarterly Outpatient Drug List.

5. The Pharmacy Program uses several investigative and screening methods to detect any abuse on the part of the prescriber, pharmacy, or recipient. Computer print-outs are reviewed periodically (e.g., quarterly). Data is compared against norms of the specific medical service areas for number of prescriptions per recipient, cost per prescription, and cost per recipient. If the figures show significant deviations from the norms, the pharmacy is flagged for in-depth review. Records are more thoroughly examined and physician, pharmacy and recipient contacts are initiated to determine the cause for the unusual pattern of care. If inappropriate practices are found to be provider oriented, the case(s) is (are) referred to the respective Peer Review Committee for recommendations for Program action, which could include non-payment and/or suspension from the Program.

6. The Kentucky Medical Assistance Program Outpatient Drug List

The KMAP Outpatient Drug List indicates the specific drugs which are covered by the Program. Limitation in available funds has necessitated the development of the Drug List. The Drug List is evaluated and revised in accordance with recommendations from prescribers and pharmacists who participate in the Program, in accordance with funds available, and in accordance with the interests and needs of Program recipients. Information obtained from consultation with the Formulary Subcommittee (an advisory committee appointed by the chairman of the Advisory Council for Medical Assistance), and with practitioner/staff associated with medical schools in the State is also utilized in accomplishing revisions to the Drug List.

SECTION IV - SERVICES COVERED

7. Prescription Quantities

It is expected that prescribers will prescribe the quantities which most nearly fulfill the recipient's needs with due regard for economy and prevention of wastage. Quantities of medication dispensed must be the same as prescribed by the physician. The KMAP will not reimburse those prescriptions when quantities prescribed have been changed by the pharmacy without approval by the physician. This policy will be monitored through post payment review.

Prescriptions should be filled for the EXACT quantity ordered by the prescriber. If a change in quantity is made, the PRESCRIBER must approve of the change and properly document it in the patient's record and include the following information:

- a. the authorized changed quantity amount
- b. the reason for the change
- c. certification that the pharmacist contacted the prescriber and requested the change which the prescriber then authorized
- d. the name of the pharmacist requesting the change
- e. the date of authorization for quantity change

Also, the PHARMACIST must properly document the change in quantity either on the Rx itself or on an attached document and include the following information:

- a. the authorized changed quantity amount
- b. the reason for the change
- c. certification that the prescriber has been contacted and concurred with the change
- d. the name of the prescriber and name of any office worker who transmitted authorization on behalf of the prescriber
- e. date of authorization for quantity change
- f. name of pharmacist receiving authorization and filling the prescription
- g. prescription number involving quantity change

SECTION IV - SERVICES COVERED

Program coverage will not be allowed for duplicate prescriptions - i.e. more than one prescription for a drug listed under the same reference number (generic category) and dispensed to the same recipient by the same pharmacy on the same day.

8. Prescriptions: New and Refills of Originals

Prescribers must properly document (either in the patient's chart or in the Refill Log as the case may be) all Rx's prescribed by them for Medicaid patients and include the following information:

- a. drug name
- b. strength and dosage of drug
- c. quantity
- d. refill limits
- e. days supply
- f. instructions for taking medicine

Prescriptions covered under the KMAP Outpatient Drug List and through the Pre-Authorization Program cannot be refilled more than five (5) times or more than six (6) months (180 days) from the date of the original prescription. Once a prescription has reached this stage, a new prescription must be authorized and signed by the prescriber in accordance with provisions in #13. Prescription Authorization and a new prescription number must be assigned.

When listing refills on the billing statement, the original prescription number should be entered. Only the date of service would differ from the information pertaining to the original prescription.

Prescriptions bearing refill instructions should be refilled at appropriate intervals as shown by the dosage schedule on the prescription for the specific drug.

SECTION IV - SERVICES COVERED

PRESCRIPTION REFILL NOTATIONS - State regulations require that the pharmacist record refills of all prescription-legend drugs by writing the date of the refill together with his/her name or initials on the back of the original prescription. The date of the refill may be stamped on the prescription if the pharmacist so desires.

In instances where the KMAP has been billed for prescription refills for which no documentation exists in the dispensing pharmacy's records the charge will be disallowed or a refund must be made by the dispensing pharmacy to the Kentucky State Treasurer in the amount of Program payment for unauthorized refills.

If computerized prescription records are maintained, adherence to the requirements of Kentucky Board of Pharmacy Regulation 201 KAR 2:170 is acceptable for prescriptions for which Kentucky Medical Assistance Program payment is requested and made.

9. Legal Requirements

Current Federal and State regulations will pertain in all instances where the KMAP requirements do not specify a more stringent policy.

10. Product Standards

Standards for quality, safety, and effectiveness of drugs for which the KMAP makes payment shall be those set forth in the "United States Pharmacopeia" or "National Formulary," where applicable, in any directives issued by the Food and Drug Administration, where applicable, and in any state or federal regulations, where applicable.

11. Prescription Substitution

Except as provided by Kentucky's Drug Product Selection ("Generic Drug") Law, specified or express permission, approval, or consent of the prescriber is required before a pharmacist may substitute any other drug, medicine, chemical, or pharmaceutical preparation.

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If such approval or consent is obtained from the prescriber, the brand name or the name of the manufacturer of the drug, medicine, chemical, or pharmaceutical preparation dispensed must be written on the prescription by the pharmacist.

12. Prescription Authorization

A supervising physician must sign all prescriptions prescribed by an intern working under his/her direct supervision in a medical teaching institution.

Practitioner authorization, i.e. actual signature of the prescriber shall be required on all prescriptions not phoned in, on all Schedule II controlled substance prescriptions, and when the physician override (certification of brand name necessity) procedure is being used. For telephone prescriptions (but not including the preceding) the pharmacist shall enter on the prescription form the name of the prescriber and the initials of the pharmacist. Since the date and signature of the pharmacist must appear on all oral prescriptions for Schedule III, IV, and V controlled substances, additional initialing by the pharmacist is not required.

13. Outpatient Drug List

The Outpatient Drug List is provided as a publication separate from this manual. Changes to this list are mailed on a monthly basis.

14. Additions To Outpatient Drug List

Drug products conforming EXACTLY in active ingredient content to the respective generic name on the Drug List can be added to the KMAP Outpatient Drug List when requested by prescribers and pharmacists who participate DIRECTLY (i.e. either prescribe drugs for or dispense prescriptions to KMAP recipients) in the KMAP, if the following conditions are met:

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- a. The name, address, telephone number, prescriber license number or KMAP primary care number, of the individual initiating the request must be provided.
- b. The requested drug product must have an "effective" or "probably effective" FDA rating.
- c. A copy of the notification of New Drug Application (NDA) or Abbreviated New Drug Application (ANDA) approval from the Bureau of Drugs and/or Office of New Drug Evaluation, National Center for Drugs and Biologics, Food and Drug Administration (FDA), Rockville, Maryland, must be provided, or the requested drug product must be included as an approved drug in the current edition of the FDA publication, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations." (Note: This requirement will not apply to products marketed originally prior to 1938.)
- d. COMPLETE information regarding the requested drug product must be provided and certified to the KMAP. This includes: generic name, product name, manufacturer name, distributor name (if different), National Drug Code Number, package size, cost to pharmacy of most frequently purchased packaged size, strength and dosage form, listing of all active ingredients together with respective strength of each ingredient. (Note: Forms for the submission of this required information are available from the KMAP, upon request.)

Also, if a requested product falls within a multiple source group which includes products deemed to be therapeutically equivalent by the Food and Drug Administration (FDA) and so designated by an "A" code in the FDA publication referenced in c. above, the requested product also must have an "A" code in order to be added to the KMAP Outpatient Drug List.

- e. The requested drug product must conform exactly in active ingredient content to the respective generic entity.

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15. Drug Pre-Authorization

The Pharmacy Program includes a drug pre-authorization procedure which supplements the KMAP Outpatient Drug List. Some medications, which are not on the Drug List and which are essential for a recipient to avoid hospitalization or higher levels of care, may be made available through this procedure. Physician consultants and agency employed nurses review each request and make determinations on the basis of Program criteria.

Certain criteria must be met before the drug is approved. (See Appendix.) If the requested drug is approved, the recipient's choice of pharmacy is contacted to determine whether the pharmacy will provide the approved drug.

The original authorization is valid for a time determined on an individual basis - provided the recipient remains eligible and the need for the drug continues to exist.

Information regarding pre-authorization may be obtained by calling TOLL FREE 1-800-372-2986.

16. Lock-In

a. Utilization Review:

Utilization review of recipient participation patterns occasionally demonstrates exceptional and excessive use of Program benefits. Recipients in this category may be placed in lock-in status which limits their physician and pharmacy benefits.

The recipient will remain on the Lock-In Program until the utilization profiles indicate a normal utilization pattern for the recipient's condition. Lock-in limitations only apply to physician and pharmacy services, and do not preclude needed emergency services or referral.

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b. Identification of Lock-In Recipients:

Lock-In recipients are identified by a special, pink Medical Assistance Identification Card. Each eligible member of a Lock-In family unit will be issued this special MAID Card monthly. The names of the recipient's Lock-In pharmacy and/or physician provider will be entered on the MAID card each month.

c. Pharmacy Profiling System

Each Lock-In recipient is entitled to Pharmacy services as prescribed by their Lock-In Physician. The number of prescriptions and days' supply are monitored by the selected Lock-In Pharmacist, by use of a profiling system.

Occasionally unique situations arise, which necessitate the dispensing of medication in a manner which deviates from the general guidelines of the Lock-In Program (i.e., more than 4 prescriptions per month). In these situations, the Pharmacist is encouraged to exercise his professional judgement in dispensing the medication(s). If a questionable case should arise, the Pharmacist is encouraged to contact the Lock-In Coordinator for verification of coverage.

The advantages of profiling systems have demonstrated an improved utilization of medication as well as a significant cost savings through a reduction of unnecessary prescriptions.

Program staff will conduct retrospective reviews of utilization patterns and any problems that are identified will be discussed with the Pharmacist.

d. Emergency Situations

If a recipient should request medications from a Pharmacist OTHER THAN THE LOCK-IN PHARMACIST, careful inquiry should be made concerning the reason (emergency - recipient out of town, Lock-In Pharmacist out of medication, etc.) for the request.

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If it is determined by the Pharmacist that a real emergency or unique situation exists, the prescription should be dispensed and the Lock-In Coordinator notified by mail or phone, to assure reimbursement. See Page 4.13, Section IV, #8, Lock-In Recipients for further information.

17. Procedure Code

The procedure code to be billed for all prescriptions is 99199.

18. Drug Utilization Review

Drug Utilization Review (DUR) is designed to monitor prescription drug use by Medicaid recipients. The purpose of the DUR is to identify and help resolve problems potentially related to drug therapy. Therapeutically oriented criteria are applied to all medical history profiles and the high risk patients are then confidentially reviewed by a Drug Utilization Review Committee composed of a practicing physician, pharmacist, and registered nurse.

I. Clinical Pharmacist's Services

Clinical pharmacist's services, provided by a licensed pharmacist on the staff of the Primary Care Center, include obtaining and recording recipient medication histories, monitoring drug use, contributing to drug therapy, drug selection, counseling, administering drug program, and surveillance for adverse reactions, and drug interactions.

Individual clinical pharmacist service counseling rendered eligible recipients is a cost-allowed service and shall be documented in the patient's records. Services may be reported on the year-end cost report as a cost of the center's total cost, but can not be billed on the MAP-7.

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J. Audiology

Audiology services provided by the Primary Care Center are limited to the services covered through the Hearing Services element of the KMAP. All audiologists must hold a current, unrevoked and unsuspended Kentucky audiologist's license issued by the State Board of Examiners for Speech Pathology and Audiology under KRS Chapter 334. An out-of-state audiologist who holds a Certificate of Clinical Competence issued by the American Speech and Hearing Association, as well as appropriate licenses as required by the state in which he or she practices, may also participate in the KMAP.

All hearing aid dealers must hold a current, unrevoked and unsuspended license issued by the Kentucky Board for Licensing Hearing Aid Dealers under requirements set forth in KRS Chapter 334 or hold a current, unrevoked and unsuspended certificate of endorsement.

If an audiologist meets Program requirements for participation as both an audiologist and as a hearing aid dealer, and is engaged in the practice of both, he may participate in the KMAP as either an audiologist or as a hearing aid dealer, but not both.

All services covered under the Hearing Services element of the Program are currently limited to eligible recipients who have not yet reached their twenty-first birthday (coverage for those turning 21 will continue through the end of their birth month).

1. Audiological Services

- a. Program coverage includes a complete hearing evaluation provided an eligible recipient by an audiologist who meets the requirements for licensure in Kentucky.*

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- b. Additional coverage extends to a hearing aid evaluation provided by such an audiologist to an eligible recipient, when such is indicated by the results of the hearing evaluation.*

*Equipment utilized in performance of these tests must meet ANSI Standards and Specification. The audiometer should be checked at least once per year to assure proper functioning; proof of calibration and/or repairs should be available. The audiometer should be checked periodically by a simple listening test with the same person doing the testing, that person being familiar with the levels at which his hearing responds at each frequency.

- c. When a hearing aid has been fitted as the result of the above evaluations, Program coverage includes up to three follow-up visits over a six-month period to insure that the recipient has become properly adjusted to the new hearing aid. Such follow-up should include counseling of recipient and family as to proper use and care of the aid, plus attention to any psycho-social problems resulting from loss of hearing and the wearing of the aid.
- d. Six months after final fitting of the hearing aid, a follow-up visit by the recipient to the audiologist is required.
- e. Should loss of or extensive damage to a hearing aid purchased through the Program necessitate replacement of the aid, the Program covers the audiologist's complete re-evaluation of the hearing loss.
- (1) When replacement of the hearing aid becomes necessary within one year of the original fitting, the second aid will be fitted upon the recommendation of the audiologist.

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- (2) When replacement of the hearing aid becomes necessary more than one year after the original fitting, the recipient must be examined by a physician and his hearing loss re-evaluated by an audiologist.
- f. Should medical, physical, or other conditions pertinent to the recipient's hearing loss change to such extent that use of a hearing aid other than the one originally fitted is indicated, the Program covers the audiologist's complete re-evaluation of the hearing loss.

NOTE: The audiologist is required to give the appropriate written, signed, and dated statements regarding the replacement aid as described for recommendation and fitting of the original aid. See page 4.71, Hearing Aids, 2b.

- g. Exclusions from Benefits - The following services are at the present time excluded from Program benefits:
- (1) Routine screening of individuals or groups for identification of hearing problems. Program coverage extends only to those hearing evaluations performed when the recipient has been referred to the audiologist or hearing clinic by a physician or when there has been some indication of hearing loss prior to the evaluation.
 - (2) Hearing therapy except as covered through six-month adjustment counseling following fitting of a hearing aid.
 - (3) Instruction in lip reading, except as covered in six-month adjustment counseling following fitting of a hearing aid.
 - (4) Any item or service for which the individual has no obligation to pay and which no other person has a legal obligation to provide or pay for.

SECTION IV - SERVICES COVERED

- (5) Benefits are limited to those eligible recipients who have not yet reached their twenty-first birthday. Those 21 and over are currently excluded.

2. Hearing Aids

- a. The KMAP can make payment to a participating hearing aid dealer for a hearing aid provided to an eligible recipient, when that recipient has been examined by a physician and an audiologist who meets Program standards for participation. Examinations by, and recommendations of, the physician and the audiologist must be rendered within ninety (90) days prior to the fitting. (This 90-day period begins on the date of the physician's examination or the audiologist's evaluation, whichever is earlier.)
- b. Reimbursement by the Program for the hearing aid will be authorized only when the physician has examined the recipient and the audiologist has verified the recipient's hearing loss and has recommended that a hearing aid is necessary and will improve the recipient's hearing ability. Also, the hearing aid dealer must have provided the recipient with an aid specifically recommended by the audiologist.

If a hearing aid is needed as a result of the hearing evaluation and the hearing aid evaluation, the audiologist must recommend that an aid be fitted for the recipient who is given the following papers:

- (1) The written, signed, and dated Statement of Medical Clearance from the examining physician and
- (2) A written, signed, and dated recommendation for a hearing aid to include the make and model of the hearing aid. The recipient should be instructed to then take these to a KMAP participating hearing aid dealer to obtain the recommended hearing aid.

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- c. General Program coverage extends only to monaural hearing aids.
- d. When the recipient suffers from refractive error and the audiologist recommends use of an eyeglass hearing aid, Program payment can be made for the hearing aid and for the eyeglass temples. Other financial arrangements may be made by the hearing aid dealer for payment of any incurred cost of eyeglass fronts or lenses.
- e. Program reimbursement for the hearing aid is to be considered payment in full for all components and attachments necessary for initial, successful operation of the instrument*, plus general service to the instrument for a period of one year. General service is to include any cleaning, adjustment, and minor repairs to the instrument, which do not necessitate return of the instrument to the manufacturer. When Program payment is requested for the hearing aid, the dealer agrees to accept this payment as payment in full for the above items and services, even though the amount of Program payment may not equal his usual and customary charge for the hearing aid. Additional remuneration may not be accepted from the recipient or any other source toward these items or services. *Eyeglass Hearing Aid exception - See preceding paragraph.
- f. Cords - The Program will reimburse the hearing aid dealer for replacement cords necessary for proper functioning of the hearing aid.
- g. Repairs - The Program will reimburse the hearing aid dealer for necessary repairs to the hearing aid, when such repairs entail replacement of vital components of the aid and necessitate return of the aid to the manufacturer. No reimbursement will be made by the Program for repairs normally covered by the manufacturer's guarantee.

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h. Replacement of aid

- (1) Should a hearing aid purchased through the Program be lost, or damaged to an extent which makes effective repair impossible, the Program can make payment for a replacement hearing aid. In case of extensive damage, written verification must be obtained from the manufacturer attesting to the impossibility of repair of the aid.
 - (a) If replacement becomes necessary within one year of the original fitting, the second aid will be fitted upon the recommendation of the audiologist.
 - (b) If replacement becomes necessary after the original fitting, the recipient must be examined by the physician and his hearing loss re-evaluated by an audiologist.
- (2) Should medical, physical, or other conditions pertinent to the recipient's hearing loss change to such extent that use of a hearing aid other than the one originally fitted is indicated, the Program can make payment to the audiologist for a complete re-evaluation of the hearing loss. Recommendation for the fitting of a replacement aid must be received from an audiologist, through the same procedures followed in the fitting of the original hearing aid.
 - (a) Replacement will not be covered upon request by the recipient only.
 - (b) Replacement for the sole purpose of incorporating recent improvements or innovations in hearing aids will not be covered, unless such replacement will result in appreciable improvement in the recipients hearing ability, as determined by evaluation of the audiologist. In such cases, the audiologist's full written explanation must accompany the hearing aid dealer's billing for the fitting.

SECTION IV - SERVICES COVERED

- i. Exclusion from Benefits - The following items are specifically excluded from Program coverage. Payment for same may be requested from the recipient if applicable.
- (1) Binaural hearing aids. Each recipient is limited to one aid per ear per date of service. A replacement aid can be processed at a later date if the replacement aid is for the same ear.
 - (2) Replacement batteries for the initially purchased hearing aid.
 - (3) Replacement earmold for the initially purchased hearing aid.
 - (4) Telephone switches, unless built in by manufacturer as standard part of hearing aid and included in standard charge for hearing aid.
 - (5) Devices for listening to radio and television.
 - (6) Other accessories not usually part of a standard hearing aid and unnecessary for basic operation of a hearing aid.
 - (7) Preparations for cleaning of hearing aids.
 - (8) Ointments and drops for relief of irritation caused by wearing of hearing aid.
 - (9) Any item or service for which the recipient has no obligation to pay and which no other person has a legal obligation to provide or pay for.

SECTION IV - SERVICES COVERED

Procedural Coding

Covered services provided by an eligible audiologist and/or hearing aid dealer on the staff of the primary care center should be entered on the MAP-7, Invoice form.

A. Procedure Codes

The following are codes used in billing the covered services reimbursable to audiologists:

- V5000 Audiometric Exam - Hearing Exam Including The Measuring of Hearing Acuity and Tests Relating to Air Conduction, Bone Conduction, Speech Reception, Threshold and Speech Discrimination
- V5010 Hearing Aid Evaluation Test
- V5020 Conformity Evaluation (Up to 3 Visits Within 6-month Period Allowable)
- W0030 Six-Month Follow-Up Visit

B. Procedures codes

The following are codes used in billing the covered services reimbursable to a hearing aid dealer. Billings for hearing aids must include the needed attachments with the submitted MAP-7 in accordance with the following:

1. Initial Aid

- (a) Attach a signed, dated specification for the hearing aid to include name, make and model,
- (b) Attach a signed and dated statement of Medical Clearance from the examining physician, and
- (c) Laboratory Invoice from the manufacturer for the cost of the aid, earmold, and batteries.

SECTION IV - SERVICES COVERED

2. Replacement Aid (Less than 12 months since previous aid was fitted.)

- (a) (Same as #1a)...and
- (b) Attach the manufacturer's statement of irreparable damage to the previous aid if applicable.
- (c) Attach a signed, dated statement of significant hearing improvement with the use of the new aid from the audiologist, and
- (d) Same as 1,c.

3. Replacement Aid (Over 12 months since previous aid was fitted)

- (a) (Same as #1(a))...and
- (b) (Same as #2(b))...or
- (c) (Same as #2(c))...and
- (d) (Same as #1(c))...and
- (e) (Same as #1(b)).

- a. V5030 Hearing Aid, Monaural, Body Worn, Air Conduction
- V5040 Hearing Aid, Monaural, Body Worn, Bone Conduction
- V5050 Hearing Aid, Monaural, In The Ear
- V5060 Hearing Aid, Monaural, Behind The Ear
- V5090 Dispensing Fee
- V5170 Hearing Aid, Cros, In The Ear
- V5180 Hearing Aid, Cros, Behind The Ear
- V5210 Hearing Aid, Bicros, In The Ear
- V5220 Hearing Aid, Bicros, Behind The Ear
- W0073 Earmold (To be billed only with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)

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- W0074 Battery (To be billed only with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)
- b. W0080 Professional Fee for Replacement of Cord
 - W3051 Replacement of Cord
- c. W0090 Professional Fee for Repair of Aid
 - W3052 Cost of Aid Repair
- d. W0075 Adaption of the Hearing Aid for use with a Bone Oscillator and Headband (To be billed only with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)

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K. Vision

Vision care services are limited to the services covered through the Vision Care Services element of the Medical Assistance Program.

1. Eligibility Requirements

The recipient must be eligible for services when the supplies (eyeglasses) are ordered, since the order date is considered to be the "Date of Service" when billing for professional procedures and laboratory procedures. This date will be the same as found on the laboratory invoice which must be attached to bills. (Approval of a prior authorization does not mean the recipient is eligible at the time of approval or at a later date.)

2. Diagnostic Services

The Program can reimburse optometrists for examinations and limited diagnostic services for all eligible recipients, regardless of age. Please refer to the American Optometric Association (AOA) 1984 Edition Booklet entitled, "Optometric Procedures - Diagnostic and Treatment" Section I, II, and IV. Of the services listed therein, the following are NOT covered:

Section II - INDEPENDENT OPTOMETRIC DIAGNOSTIC PROCEDURES

I. MICROBIOLOGY SERVICES

J. UNLISTED DIAGNOSTIC PROCEDURE

Section IV - SPECIAL SERVICES AND REPORTS

ADMINISTRATIVE SERVICES (Exception 99050 - Services requested after hours in addition to basic service.)

Limitations on Covered Office and Home Visits

New patient office medical services codes 90000, 90010, 90015, 90017 and 90020 are limited to one (1) per patient, per provider per twelve (12) month period.

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Established patient medical services codes 90070, 90080, and 90170 are limited to one (1) per patient, per provider, per twelve (12) month period.

New patient home medical services codes 90100, 90110, 90115, and 90117 are limited to one (1) per patient, per provider, per twelve (12) month period.

Procedure codes 92002 and 92004 are limited to one (1) per patient, per provider, per twelve (12) month period.

Procedure codes 92012 and 92014 are limited to one (1) per patient, per provider, per twelve (12) month period.

Procedure codes 92002, 92004, 92012, and 92014 may NOT be used with the following procedure codes: 90000, 90010, 90015, 90017, 90020, 90030, 90040, 90050, 90060, 90070, and 90080.

3. Eye and Ocular Adnexa Services

Coverage of the following services is effective with July 15, 1986, dates of service and thereafter. Compliance with the effective date of this coverage will be enforced through post-payment review.

- | | |
|-------|---|
| 65205 | Removal of foreign body, external eye; conjunctival superficial |
| 65210 | Removal of foreign body, conjunctival embedded (includes concretions), subconjunctiva or scleral nonperforating |
| 65220 | Removal of foreign body, corneal, without slit lamp |
| 65222 | Removal of foreign body, corneal, with slit lamp |
| 67820 | Correction of trichiasis, epilation, by forceps only |
| 68800 | Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral |
| 68820 | Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral |

SECTION IV - SERVICES COVERED

4. Eyeglasses

a. Conditions of coverage

The KMAP can cover eyeglasses when the following conditions are met. The KMAP requires that the services listed in this subsection 4. Eyeglasses be prior authorized before payment is made. Prior authorization Form MAP-8 and instructions for completion can be found in the Appendix.

(1) Age

The Program can cover laboratory costs of frames, lenses, and appropriate dispensing fee for services rendered to all eligible recipients up to the age of 21 (coverage for those turning 21 will continue through the end of their birth month).

(2) Diagnosis

Eligible recipients must be in one of the following four categories:

- (a) Amblyopia
- (b) Post surgical eye care
- (c) Low or subnormal vision
- (d) Other diagnostically indicated need for eyeglasses

(3) Minimum Prescription

Visual conditions requiring prescriptions for correction shall contain power in the stronger lens no weaker than the following:

+0.50 or -0.50 sphere +0.50 or -0.50 cylinder
0.50 diopter of vertical prism
A total of 2 diopters of lateral prism

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(4) Frame and Lenses Requirement

(a) Frame

- 1) All frames must be of domestic distribution, first quality and free of defects. The material must be normally resistant to damage or breakage, and must be finished with a high polish.
- 2) To enable replacement of lenses and frame parts, all frames must have imprinted on them the following information: Eye size, bridge size, temple length, and the manufacturers' name or trademark.
- 3) The provider must allow the patient to try on and select from an adequate selection of appropriate, approved frame styles. The minimum selection is to be three each of girls' and boys' frame styles, and three sizes of each style. The recipient may use his own frame if he or she chooses.

(b) Lenses

- 1) Only first quality lens may be used. They must be available in a complete range of corrected curves. They must be free of defects and packaged in the manufacturers original envelope or box, and must meet the inspection, tolerance, and testing procedures of the American Standard Prescription Requirements.
- 2) Unless contraindicated, case hardened lenses should be prescribed for all recipients.

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- 3) In those cases where a change in prescription has been made within twelve consecutive months, only the lenses are to be changed and must meet the minimum change in prescription stated under limitations in coverage. The frame cannot be replaced if it is intact and appropriate.

NOTE: Supplies and materials other than eyeglasses and visual aids used in a diagnostic service such as eye drops, cotton swabs, etc. are considered to be part of the service therefore they are included in the payment for the service rendered and additional charges may not be made to the Program or the recipient for these items.

b. Limitations in coverage

- (1) Recipients are limited to 2 pairs of glasses per 12 months in accordance with the following:

-The recipient may have two complete pairs of eyeglasses within a 12 month period beginning with the date of his/her first or initial pair. (Recipients are limited to one initial pair within 12 months.) The second or replacement pair may be a completely new pair of glasses.

OR

-The recipient may receive 2 replacement pairs of glasses within 12 months beginning with the date he receives his first replacement pair;

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OR

-The recipient may receive any combination of parts for his/her glasses; e.g., 2 fronts, 1 temple, 4 lenses; so long as the total parts combined make up NO more than two pairs of glasses;

OR

-The recipient may receive one initial pair or one replacement pair and any combination of parts so long as the total parts combined make up no more than one additional pair of glasses.

(2) Changes in prescription must meet a minimum of:

±0.50 sphere

±0.50 cylinder

1.00 cylinder or less--10° change in axis

1.25 cylinder or greater--5° change in axis

(3) Telephone contacts are excluded from payment.

(4) Contact lenses are excluded from payment. However fitting of contact lenses is payable but must meet one of the following criteria:

(a) CORRECTED acuity in the best eye is 20/50 and can be improved with use of contact lenses or;

(b) Visual prescription of ±8.00 diopter or greater, or;

(c) 4.00 diopter anisometropia (difference in power between eyes) or;

(d) MEDICALLY INDICATED or MEDICALLY NECESSARY is written or typed on claim form or attach the same in the form of a written or typed note or a formal attachment such as the invoice or patient chart to the claim form. The patient's record must document that this method of correction was medically necessary or medically indicated.

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- (5) Safety glasses are excluded from payment except in those cases where the recipient is blind in one eye or has only one eye. In these cases, this must be entered on both the pre-authorization request and the billing form.
- (6) Tint is payable only if the prescription specifically states the diagnosis of photophobia. This must be entered on both the pre-authorization request and the billing form.
- (7) Program reimbursement for eyeglasses must be considered payment in full. The cost of both laboratory materials and dispensing fees must be billed to either the Program or the recipient. Should any portion of the amount be billed to or paid by the recipient, no responsibility for reimbursement shall attach to the Department and no bill for the service shall be paid by the Department.

5. Dispensing of Eyeglasses

This includes single or bifocal vision prescription, services to frames, and delivery of completed prescription.

- a. SINGLE VISION PRESCRIPTIONS. The lens selection and design should meet the recipient's physical, occupational, and/or recreational requirements. The finished prescription must be verified by the prescriber to ascertain that it meets the lens power and lens specifications ordered. It is the responsibility of the prescriber to ascertain that only first-quality materials approved by the KMAP are being provided the recipients, and that the fabrication conforms to the standards. The prescriber shall be responsible at no further cost to the KMAP or the recipient for the replacement of inaccurately filled prescriptions, non-authorized materials, defective materials, or improperly fitting lenses.
- b. BIFOCAL PRESCRIPTIONS. Same requirements as #1 unless contraindicated Kryptok bifocals are prescribed.

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- c. SERVICES TO FRAMES. This includes frame selection and measuring to meet the recipient's facial fitting, occupational and/or recreational requirements. The provider must allow the patient to try on and select from an adequate selection of appropriate, approved frame styles. The minimum selection is to be three each of girls' and boys' frame styles, and three sizes of each style. The recipient may use his own frame if he or she so chooses. The finished prescription should be verified by the provider to ascertain that it meets the frame specifications ordered. It is the responsibility of the provider to ascertain that only first-quality materials approved by the KMAP are being provided the recipients. The provider shall be responsible at no further cost to the KMAP or the recipient for inaccurately filled prescriptions, non-authorized materials, defective materials, or improperly fitting frames.
- d. DELIVERING COMPLETED PRESCRIPTION. This includes at no further cost to the KMAP or the recipient instructing the recipient in the use of the prescription, adjustment of the prescription, and subsequent minor adjustments for a period of one year.
6. Professional Services for Dispensing and Repairing Eyeglasses

The procedure codes for dispensing and repairing eyeglasses as contained in the American Optometric Association (AOA) 1984 Edition Booklet entitled, "Optometric Procedures - Diagnostic and Treatment," Section III are as follows:

- 92340 - Professional fee for the dispensing of the INITIAL
92341 - PAIR of eyeglasses. The initial pair always
92352 - includes BOTH the frame and lenses.
92353 -
- 92370 - Professional fee for the dispensing of a REPLACEMENT PAIR or part of the eyeglasses. When a lens prescription change is necessary while the frame continues to be functional, even longer than 12 months, the replacement code should be used.

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W0091 - Hinge Repair - This is inclusive of both the professional fee and supply cost. Do NOT bill with procedure code for professional services.

Of the services listed in the (AOA) 1984 Booklet, the following are NOT covered:

Section III - OPTOMETRIC TREATMENT SERVICES

A. OPHTHALMIC LENS TREATMENT SERVICES

92342 Treatment with spectacles, except for aphakia; multifocal, other than bifocal

92358 Prosthesis service for aphakia, temporary

B. CONTACT LENS TREATMENT SERVICES

92070 Prescription and management of contact lens for treatment of disease, including supply of lens.

92325 Modification of contact lens

92326 Replacement of contact lens

C. LOW VISION TREATMENT SERVICES

D. VISION THERAPY SERVICES

The (ICD-9-CM) and (COPT) procedure coding structures are not acceptable.

E. PROSTHETIC EYE SERVICES

F. ANISEIKONIC TREATMENT SERVICES

G. OTHER PROCEDURES

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7. Laboratory procedure codes for eyeglasses and parts are as follows:

V2020	Frames, Purchases
V2100	Sphere, Single Vision, Plano to Plus or Minus, 4.00, Per Lens
V2101	Sphere, Single Vision, Plus or Minus 4.12 to Plus or Minus 7.00D, Per Lens
V2102	Sphere, Single Vision, Plus or Minus 7.12 to Plus or Minus 20.00D, Per Lens
V2103	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2104	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2105	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2106	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, Over 6.00D Cylinder, Per Lens
V2107	Spherocylinder, Single Vision, Plus or Minus 4.25 to Plus or Minus 7.00 Sphere, .12 to 2.00D Cylinder, Per Lens
V2108	Spherocylinder, Single Vision, Plus or Minus 4.25D to Plus or Minus 7.00 Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2109	Spherocylinder, Single Vision, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2110	Spherocylinder, Single Vision, Plus or Minus 4.25 to 7.00D Sphere, Over 6.00D Cylinder, Per Lens
V2111	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, .25 to 2.25D Cylinder, Per Lens
V2112	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 2.25D to 4.00D Cylinder, Per Lens
V2113	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 2.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2114	Spherocylinder, Single Vision, Sphere Over Plus or Minus 12.00D, Per Lens
V2115	Lenticular, (Myodisc), Per Lens, Single Vision

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V2116	Lenticular Lens, Nonaspheric, Per Lens, Single Vision
V2117	Lenticular, Aspheric, Per Lens, Single Vision
V2118	Aniseikonic Lens, Single Vision
V2199	Not Otherwise Classified, Single Vision Lens
	Bifocal, Glass or Plastic (Up to and Including 28mm Seg Width, Add Power Up to And Including 3.25D)
V2200	Sphere, Bifocal, Plano to Plus or Minus, 4.00D, Per Lens
V2201	Sphere, Bifocal, Plus or Minus 4.12 to Plus or Minus 7.00D, Per Lens
V2202	Sphere, Bifocal, Plus or Minus 7.12 to Plus or Minus 20.00D, Per Lens
V2203	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2204	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2205	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2206	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, Over 6.00D Cylinder, Per Lens
V2207	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2208	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2209	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2210	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, Over 6.00D Cylinder, Per Lens
V2211	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 25 to 2.25D Cylinder, Per Lens
V2212	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 2.25 to 4.00D Cylinder, Per Lens
V2213	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2214	Spherocylinder, Bifocal, Sphere Over Plus or Minus 12.00D, Per Lens
V2215	Lenticular, (Myodisc), Per Lens, Bifocal
V2216	Lenticular, Nonaspheric, Per Lens, Bifocal
V2217	Lenticular, Aspheric Lens, Bifocal

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V2218	Aniseikonic, Per Lens, Bifocal
V2219	Bifocal Seg Width Over 28mm
V2220	Bifocal Add Over 3.25D
V2299	Specialty Bifocal
V2410	Variable Sphericity Lens, Single Vision, Full Field, Glass or Plastic, Per Lens
V2430	Variable Sphericity Lens, Bifocal, Full Field, Glass or Plastic, Per Lens
V2499	Not Otherwise Classified, Variable Sphericity Lens
W0094	Front Only
W0093	One Temple Only
W0092	Two Temples Only

8. Miscellaneous Services

W0091 Hinge Repair - This is inclusive of both the professional fee and supply cost. Do NOT bill with procedure code for professional services.

All of the above procedure codes represent one unit of service and must be entered as such on the billing form.

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L. Home Health Services

The home health component of a primary care center must meet the standards for, and include, the same provision of services as the home health element of the KMAP. The component must be licensed as a home health agency, and be certified for participation under Medicare (Title XVIII).

If a primary care center meets the above requirements and wishes to bill Title XIX for home health services, contact the Division of Policy and Provider Services at 502/564-6890 for further information.

SECTION IV - SERVICES COVERED

M. SCREENING - EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are available to all recipients from birth through age 20 who are patients of the primary care center, or who are accepted by the center as patients for EPSDT, following referral from another source (i.e. Department for Social Insurance, Department for Social Services, Local Health Department Outreach Unit, local schools, etc.).

1. The early and periodic screening services shall be under the direction of a duly-licensed physician, nurse practitioner, or registered professional nurse currently licensed by the state of Kentucky who shall be responsible for assuring that the requirements of participation are met and that the procedures established by the Program are carried out. Paramedical staff performing screening examinations and tests shall be trained and their services limited to their area of competence and in accordance with the professional practice acts governing the health disciplines.
2. The screening package shall include, but not be limited to, the following basic screening services for eligible recipients as appropriate for age and health history and in accordance with acceptable standards for preventive health care in children.
 - a. Health and developmental history
 - b. Unclothed physical examination
 - c. Developmental assessment
 - d. Vision and hearing testing

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- e. Assessment of immunization status and updating immunization
- f. Assessment of nutritional status
- g. Laboratory procedures
 - (1) Hemoglobin or hematocrit
 - (2) Sickle cell*
 - (3) Urinalysis
 - (4) Tuberculin skin test
 - (5) Lead*
 - (6) Serology for syphilis and/or*
 - (7) Culture for gonorrhoea

*When Medically Indicated

3. Screening providers will be reimbursed for the screening services outlined above, and as appropriate for age and health history, rendered to eligible Title XIX clients as soon as they are declared eligible for Medicaid, and at the following ages:

02-04 weeks	16-19 months	07-08 years
02-03 months	23-25 months	09-10 years
05-06 months	3 years	11-12 years
09-10 months	4 years	13-14 years
12-15 months	5 years	15-16 years
	6 years	17 through 20 years

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4. The clinic shall maintain a medical record for each recipient screened with all entries kept current, dated, and signed. The record shall include, but is not limited to, the following:
 - a. Patient history
 - b. Physical assessment findings
 - c. Growth and development records
 - d. Disposition of patient
 - e. Name of referral source (name of physician, dentist, etc.)
 - f. Record of immunization
 - g. Copy of agency reporting forms
 - h. Copy of referral form

5. All center records of recipients are to be completed promptly and are to be systematically filed and retained for 5 years.
 - a. The center shall have policies to provide for the systematic retention and safekeeping of recipients' medical records for the required period of time in the event that the clinic discontinues operation.

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- b. If the recipient moves to an area outside the center's service area, written permission of the parent or guardian shall be obtained so that a copy of the recipient's medical records can, and shall be, transferred to the clinic providing service in that area.
- c. Screening providers receiving requests for release of EPSDT findings to Boards of Education and/or Head Start Programs are directed to:
 - (1) Establish an agreement with the appropriate school superintendent and/or head start official to safeguard confidential information. A copy must be retained in the center's files. Individualized agreements to safeguard confidential information are not required but the agreement would cover all persons within the category living in the school district.
 - (2) Obtain written authorization for the release of EPSDT findings to school superintendents and/or head start official from the parent and/or legal guardian.
 - (3) Prior to releasing EPSDT findings, individual screening records must be marked "confidential information."
- 6. The center shall have the necessary equipment, in proper working order, to provide the basic screening tests outlined herein.

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The area utilized during the testing period of the EPSDT exam shall provide adequate privacy and a minimum of interference to assure maximum accuracy from the test.

7. The center shall make available for review and audit by authorized representatives of the KMAP at all reasonable times the medical, administrative, and financial records pertaining to services rendered to Program recipients.

Representatives of the Program will conduct (1) surveys to determine compliance with Federal, State and local regulations, and (2) fiscal audits to determine cost of care.

8. The KMAP recognizes that cases of suspected child abuse and neglect may be uncovered in regular Early and Periodic Screening Program examinations. If such cases are discovered, an oral report shall be made immediately by telephone or otherwise to a representative of the local Department for Social Services office. Within 48 hours a report in writing shall be made to the local Department for Social Services office for use in investigation and appropriate action to protect the child involved.

To facilitate reporting of suspected child abuse and neglect cases, legislation effecting the reporting of child abuse, (KRS 199.335) is printed on the reverse of Cabinet for Human Resources Child Abuse Reporting Forms (DSS-115). These forms may be secured from the local Department for Social Services office. A copy of this form is included in the Appendix.

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9. Basic Services

The following tests and assessment procedures may be used in evaluating the health status of the Program recipient. The procedures outlined are suggested testing procedures; however, APPROVED equivalent procedures may be used to obtain the desired results. The "Standards for Preventive Health Care in Children" is to be used as a reference manual.

a. Medical History

A medical history will be obtained from the parent or guardian by qualified personnel and retained in the recipient's medical record. A consent form shall be signed by the parent, guardian, or responsible person authorizing the provider to perform the basic screening tests, update the immunizations, and to share pertinent information with any state agency providing service or supervising services to the recipient.

The health service provider's professional staff (P.N., A.R.N.P., or M.D.) is responsible for obtaining the medical history. If this responsibility has been delegated by the professional to a trained paraprofessional, the professional must review the findings with the parent and/or legal guardian at the time of the physical assessment examination.

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The parent and/or legal guardian has authority to give written consent for the EPSDT service. The Department for Social Services will in some instances be the legal guardian for an eligible Medicaid recipient and therefore will have authority to give the required written consent for EPSDT services. It should be noted, however that the Department for Social Services only has this authority for those cases committed by the courts to their care, i.e. foster care children.

b. Procedures and Tests

The following procedures and tests shall be performed in accordance with acceptable standards for preventive health care in children, as appropriate for age and health history.

- (1) All recipients of screening services shall have their height and weight recorded and their growth percentile measured using a standard chart. Development shall be assessed by health history, physical findings, appraisal of the significant milestones of the maturation process, and utilization of standard growth and development charts.

Standard growth charts constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control may be secured by request from the Division of Medical Assistance.

- (2) A blood pressure shall be taken on eligible recipients over 35 months of age and/or on all recipients of screening services when indicated.

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- (3) A routine throat inspection shall be done on each recipient by the examining physician, nurse, or nurse practitioner.
- (4) A routine dental inspection shall be carried out. Some of the children, 3 years of age and above, may have accepted the dental component of EPSDT and been referred at intake by outreach staff to the dentist for diagnosis and treatment.
- (5) All eligible recipients are to be checked for obvious physical defects such as hernia, orthopedic, skin, eye, etc. If any abnormality is detected, diagnosis and treatment or a referral shall be initiated.
- (6) A complete or dip stick urinalysis (blood, sugar, ketone bodies, and protein) shall be done on each recipient as appropriate for age and health history. Bacteriuria screening shall be done for the at risk groups.

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Supplies and forms for Bacteriuria screening can be obtained by writing:

Kidney Screening Program
Department for Health Services
Division of Preventive Services
275 East Main Street
Frankfort, Kentucky 40621

- (7) Visual screening shall be carried out using the appropriate Snellen Chart and/or equivalent tool. Screening results in recipients too young to utilize the standard equipment may be obtained by other means such as observation, object identification, etc.
- (8) All recipients should be checked for evidence of ear disease such as obvious infection, foreign bodies, wax impacted canal, drainage, or other abnormalities. At the age of 47 months and up an audiometric evaluation should be performed.
- (9) A hematocrit or hemoglobin shall be done on each eligible recipient as appropriate for age and health history.

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- (10) When medically indicated, all eligible recipients who are at high risk for sickle cell anemia shall be offered screening for sickle cell anemia either on-site or by referral.
- (11) Tuberculin Skin Tests shall be performed on eligible recipients who are at risk for developing tuberculosis.

NOTE: Since local and district health departments have the resources and are mandated to control tuberculosis, KMAP service providers should work with their local health departments to insure that all necessary medical, nursing and epidemiological follow-ups are provided to KMAP service recipients found to have infection or disease.

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- (12) An assessment of immunizations should be made and immunizations updated if necessary. Program payment does not include the cost of vaccines. The administration of the vaccine is included in the charge for the screening service.

NOTE: Information regarding immunizations and vaccines may be obtained by contacting:

The Department for Health Services Division of Local Health Communicable Disease and Prevention Section
275 East Main Street Frankfort, Kentucky 40621

- (13) Serology for syphilis and/or a culture for gonorrhea shall be done when the history and nursing assessment indicate the necessity.
- (14) Routine testing for lead poisoning shall not be required by the Program; however, in those cases where the physical symptoms or environmental conditions indicate possible lead poisoning, a referral should be made to the physician or to the appropriate medical service for follow-up. If referral is made for lead poisoning, the block 14 on the MAP-7 should be completed.

Referrals:

At the end of the screening process abnormalities noted should be discussed in terms understandable and meaningful to the recipient, parent and/or guardian, and arrangements initiated or referrals made for diagnosis and treatment.

It is expected that the primary care centers will provide most necessary diagnosis and treatment services, reducing the need for referrals to other providers, and establishing continuity in the patient's care and treatment.

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All referrals, either within the Center or to other outside providers, shall follow the procedures listed for setting up diagnosis and treatment appointments.

- a. Clients capable of and preferring to make their own appointments.
 - (1) Appropriate assistance is given the client by the screening provider.
 - (2) Note the screening finding on the Referral Form CH-115 and give two (2) copies of the completed referral form to the client for presentation to the referral resources.

- b. Clients unable to follow through with making appointments for diagnosis and treatment.
 - (1) The client's choice of referral resources is honored and appointments are made for diagnosis and treatment by the screening provider.
 - (2) Note the screening finding on the Referral Form CH-115 and forward two (2) copies of the completed referral form to the referral resource.

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- c. The screening provider is to:
- (1) Refer EPSDT participants to Title V services when appropriate (See Directory of Title V Services)
 - (2) Assist clients with abnormality(ies) for which treatment is not covered by the State Title XIX plan in securing needed diagnosis and treatment services at little or no cost to the client.

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- e. The KMAP requires your help as a provider of screening services in the identification and referral of clients who may be eligible for Women, Infants and Children (WIC) Supplemental Food Program.

The WIC Program is designed to provide specific nutritional foods to pregnant women; breast-feeding women, up to one (1) year postpartum; or women to six (6) months postpartum, plus infants and children under five (5) years of age, who reside in an approved area and are determined to be at nutritional risk by a health professional.

In order for the local WIC Project to be made aware of these children, you are asked to utilize the Referral Form (CH-115) for any recipient screened whom you identify as potentially eligible for WIC benefits. The completed CH-115 form should then be forwarded to your local WIC Project.

The WIC Supplemental Food Program nutritional risk criteria and a list of local WIC Projects may be secured from the Department for Medicaid Services.

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Procedural Coding

Following EPSDT services, the invoice form (MAP-7) is to be completed in accordance with the instructions in Section VI - Completion of the Invoice Form, with special attention directed to the services and tests listed in blocks #11 and #12. The following coding should be entered in each box for each service and test listed:

<u>CODE</u>	<u>ASSESSMENT</u>
A	Normal
B	Abnormal Referred
C	Abnormal under treatment

If referrals have been made, designate in blocks #14 and #15.

All EPSDT examinations will use procedure code Y6000.

SECTION IV - SERVICES COVERED

N. Health Education Services

Definition

These services must provide as a minimum appropriate personnel to present, on request, information on general health care to local school systems, civic organizations and other concerned local groups. Services are to include distribution of written material on pertinent health subjects.

Health Education counseling rendered eligible recipients on an individual basis is a cost-allowed service. Services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

O. Nutritional Services

These services must be provided by a professional nutritionist on the staff of the Primary Care Center, and must include as a minimum individual counseling relating to nutritional problems or nutritional education. Group nutritional services may also be provided.

Nutritional counseling rendered eligible recipients on an individual basis is a cost-allowed service. Services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

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P. Social Services Counseling

These services must be provided by a licensed, graduate, or certified social worker on the staff of the Primary Care Center. As a minimum, the services must include information and referral services. Intensive counseling is to be limited to crisis situations and health related problems. Individuals with other identified counseling needs are to be referred to appropriate social service agencies.

Individual social services counseling rendered eligible recipients is a cost-allowed service. Counseling services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

Q. Outreach Services

These services must be provided as a package structured to identify health care needs in the service area.

Outreach services made as part of an established plan of care for the patient and/or family, shall be documented in the patient's records as to the nature and purpose of the visit. Services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

SECTION IV - SERVICES COVERED

R. Holding/Observation Accommodations

Utilization of holding/observation accommodations maintained by the center will be covered, within the limitations outlined below:

1. Utilization by an eligible recipient will be considered a covered benefit for not more than 24 hours.
2. Decisions to hold patients shall be the responsibility of a physician(s) on the medical staff of the center.
3. A licensed nurse shall be on duty at the center when a patient is held in center accommodations beyond regular scheduled hours.
4. A duly-licensed physician shall be on call at all times during which a patient is held beyond the regular scheduled hours of the center.
5. All procedures relating to the retention of and rendition of services to patients held in center accommodations shall be set forth in the center's patient care policies.

Procedure Code: Z9084 - Holding/Observation

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. Method of Reimbursement

Primary care services are reimbursed in accordance with a cost reimbursement system, involving a cost-based, all-inclusive rate per visit at the time of service with a year-end settlement to adjust payments to allowable costs. The details of this system are explained in the Primary Care Reimbursement Manual as follows:

- Part I General Policies and Procedures
- Part II Principles of Reimbursement
- Part III Annual Cost Report Instructions
- Part IV Annual Cost Report

A billable service, one that will generate a payment of the established rate per visit, is defined as a visit or encounter which includes a face-to-face contact and a professional medical service by either a physician, physician assistant (if licensed), nurse practitioner, dentist, or optometrist on the staff of the Primary Care Center. However, if a center elects to provide home health services as an identifiable package which meets the requirements specified in the Primary Care Program regulations, any staff member providing services meeting these requirements who is eligible to bill under the existing home health element of the Medical Assistance Program may also bill under the Primary Care Program. A billable service is limited to a single professional visit on a given day regardless of the number or variety of services received during such visit (i.e., only one Medicaid bill per day can be generated). However, this does not preclude two or more billable services (i.e., Medicaid bills) from being generated if 1) the patient is seen at different locations (i.e., outstation and main center) on the same day or 2) has a second visit at the same location which resulted from a different circumstance, purpose, or need.

SECTION V - REIMBURSEMENT

B. Medicare, Title XVIII Coverage

In accordance with the Primary Care Services Principles of Reimbursement, any KMAP responsibility for a recipient's Medicare (Title XVIII) deductible and coinsurance payments for covered services will be reflected on the invoice form (MAP-7) and allocated during the year end cost settlement, (See Reimbursement Manual, Part III, cost report instructions, section 108, page 8.05.)

The Primary Care Center shall bill the appropriate Medicare (Title XVIII) fiscal intermediary, prior to billing. If billing EDS Medicare on the HCFA-1500 billing form, the primary care center must not check the "Medicaid" block on the HCFA-1500 form nor enter the Medical Assistance Identification Number and must choose one of the following: 1) Require recipient to sign the HCFA-1500 claim form for Medicare purposes; or 2) Obtain a blanket assignment from the recipient which will permit the provider to enter the words "Blanket Assignment on File" in the signature block of the HCFA-1500. The MAP-7 form shall then be completed as for any recipient, with the amount received from Medicare reported in block 29. Program payment for the services reflected on the invoice will be the center's interim rate (CAC) less the amount received from Medicare.

C. Reimbursement in Relation to Other Third Party Coverage (Excluding Medicare)

1. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services must actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, he/she should determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

SECTION V - REIMBURSEMENT

2. Identification of Third Party Resources

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., EXAMINE THE RECIPIENT'S MONTHLY ELIGIBILITY CARD FOR AN INSURANCE INDICATOR AND IF AN INDICATOR IS PRESENT, QUESTION THE RECIPIENT FURTHER REGARDING OTHER INSURANCE.

3. Private Insurance

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 the date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance

SECTION V - REIMBURSEMENT

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.

4. 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.

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.

SECTION V - REIMBURSEMENT

5. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider should pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment must be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as, the names of attorneys, other involved parties and/or the recipient's employer to the claim when submitting to EDS for Medicaid payment.

D. 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 VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General

The Health Insurance Claim Form (HCFA-1500) (12/90) shall be used to bill for all primary care services rendered eligible Kentucky Medicaid Program recipients. A claim or invoice is to be completed to reflect all services rendered a recipient on a given date, even when the services do not constitute a "billable service." A definition of billable service may be found in Section V - Reimbursement, and in the Reimbursement Manual, PART I, Section 103, page 3.01.

The original of the two part invoice set shall be submitted to EDS as soon as possible after the service is provided. The carbon copy of the invoice shall be retained by the provider as a record of claim submitted.

Invoices shall be mailed to:

EDS
P.O. Box 2018
Frankfort, Kentucky 40602

B. Completion of the Health Insurance Claim Form, HCFA-1500 (12/90)

An example of a Health Insurance Claim Form, HCFA-1500 (12/90) is shown in the appendix. Instructions for the proper completion of this form are presented below.

IMPORTANT: The patient's Kentucky Medical Assistance Identification Card shall be carefully checked to see that the patient'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. There can be no Medicaid payment for services rendered to an ineligible person.

The age of the patient will also be reflected on the Identification Card. This shall be noted, specifically in cases where the patient requires services that are limited to recipients UNDER the age of 21.

SECTION VI - COMPLETION OF INVOICE FORM

HCFA-1500 (12/90) forms may be obtained from:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402

Telephone: 1-800-621-8335

- | BLOCK NO. | ITEM NAME AND DESCRIPTION |
|-----------|--|
| 2 | PATIENT'S NAME

Enter the recipient's last name, first name, middle initial exactly as it appears on the current Medical Assistance Identification (MAID) card. |
| 9A | OTHER INSURED'S POLICY OR GROUP NUMBER:

Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card. |
| 10B,C | ACCIDENT:

Check the appropriate block if treatment rendered was necessitated by some form of accident. |
| 11 | INSURED'S POLICY GROUP OR FECA NUMBER

Complete if the recipient has any kind of private health insurance that has made a payment, other than Medicare. |
| 11C | INSURANCE PLAN NAME OR PROGRAM NAME

Enter the name of the insurer and the policy number. |
| 19 | INSURED'S GROUP NUMBER

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

SECTION VI - COMPLETION OF INVOICE FORM

21 DIAGNOSIS CODE

Enter the appropriate ICD-9-CM diagnosis codes. Does not apply to pharmacy and non-emergency dental services.

23 PRIOR AUTHORIZATION NUMBER

If the service provided requires prior authorization, enter the prior authorization number assigned by EDS.

24A DATE OF SERVICE

Enter the date on which each service was rendered in month, day, year sequence, and numeric format. For example, April 16, 1992 would be entered as 04-16-92.

24B PLACE OF SERVICE

Enter the appropriate place of service code from the list on the back of the claim form identifying where the service was provided.

24D PROCEDURE CODE

Enter the procedure code which identifies the service or supply rendered to the recipient. For pharmacy claims, enter the twelve (12) digit NDC number.

24E DIAGNOSIS CODE INDICATOR

Transfer "1", "2" or "3" from the field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.

SECTION VI - COMPLETION OF INVOICE FORM

24F PROCEDURE CHARGE

Enter your usual and customary charge for the service rendered.

24G DAYS OR UNITS

Enter the number of times this procedure was provided for the recipient on this date of service. For pharmacy services, enter the drug quantity of each prescription billed.

24H EPSDT Family Plan

Enter a "Y" if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment Examination.

24K RESERVED FOR LOCAL USE

When billing pharmacy services, enter the prescription number. When billing dental services, enter the tooth number(s). Enter the vaccine dose for vaccinations. Enter the EPSDT referral codes, if applicable, for EPSDT.

26 PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key the first seven or fewer digits. This number will appear on the Remittance Statement as the invoice number.

28 TOTAL CHARGE

Enter the total of the individual procedure charges listed in column 24F.

SECTION VI - COMPLETION OF INVOICE FORM

29 AMOUNT PAID

Enter the amount received by any other private insurance, DO NOT INCLUDE Medicare. If no health insurance payment amount, leave blank.

30 BALANCE DUE

Enter the amount received from Medicare.

31 SIGNATURE/INVOICE DATE

The actual signature of the provider (not a facsimile) or the provider's appointed representative is required. Stamped signatures are not acceptable.

33 PROVIDER NUMBER

Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight-digit individual Medicaid provider number.

* * * * *
Claims for covered services must be received by EDS within twelve
*(12) months from the date of service. Claims with service 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, Social Security
*documents, correspondence describing extenuating circumstances, *
*Action Sheets, Return to Provider Letters, Medicare Explanation *
*of Medicare Benefits, etc. *
* * * * *

SECTION VI - COMPLETION OF INVOICE FORM

- 26 No entry required.
- 27 TOTAL CLAIM CHARGE:
Enter the total of lines 1 - 10.
- 28 HEALTH INSURANCE AMOUNT:
Enter the total amount (if any) received from the patient's health insurance for services billed.
- 29 AMOUNT FROM MEDICARE:
Enter the total amount received from Medicare for services billed. Attach a copy of the Medicare Explanation of Benefits to claim.
- 30 PROVIDER NAME:
Enter the name and address of the Primary Care Center performing the services being billed.
- 31 PROVIDER NUMBER:
Enter the eight-digit Medicaid provider number assigned to the provider listed in block 30.
- 32 AUTHORIZED SIGNATURE:
The actual signature of the provider or authorized representative is entered here.
- 33 COUNTY:
No entry required.
- 34 AREA:
No entry required.

SECTION VI - COMPLETION OF INVOICE FORM

35 INVOICE DATE:

Enter the month, day, and year that the invoice was signed and submitted to Medical Assistance. (i.e., November 15, 1988 would be entered 11 15 88).

36 DATE OF SERVICE:

Enter the month, day and year (numeric equivalent as block 35) the services were provided. One date of service per claim.

37 CHARGE DISPOSITION:

No entry required.

38 INVOICE NUMBER:

No entry required.

39 No entry required.

Claims for covered services must be received by EDS within twelve
*(12) months from the date of service. Claims with service 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, Social Security
*documents, correspondence describing extenuating circumstances, *
*Action Sheets, Return to Provider Letters, Medicare Explanation *
*of Medicare Benefits, etc. *

SECTION VII - REMITTANCE STATEMENT

VII. 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 VII - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix XIII-A. This section lists all 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
PRIMARY CARE SERVICES

ITEM	DEFINITION
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 services as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form.

SECTION VII - REMITTANCE STATEMENT

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.
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
POS	Place of service code depicting the location of the rendered service
PROC	Procedure code in the line item
RX NO.	The prescription number used by the pharmacist to identify this prescription
DRUG CODE	The drug code number of the prescription that was dispensed
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 XIII-B.

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

SECTION VII - REMITTANCE STATEMENT

D. Section III - Claim in Process

The third section of the Remittance Statement (Appendix XIII-C) 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 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 XIII-D) 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.
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).

SECTION VII - REMITTANCE STATEMENT

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 XIII-E).

SECTION VIII - 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 Form2. Remittance Advice or Medicare EOMB, when applicable3. 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 VIII - 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 1-800-372-2921 (within Kentucky)
- Local (502) 227-2525

SECTION VIII - 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 VIII - 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)-372-2921 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 VIII - GENERAL INFORMATION - EDS

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

<u>Field Number</u>	<u>Description</u>
1	Enter your 8-digit 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 the date of the inquiry.

SECTION VIII - 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 VIII - 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.