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SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medical Assistance Program Family Planning 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) 564-3476. 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 Department for Human Resources, Bureau for Social Insurance, Division for Medical Assistance. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

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

As a provider of medical services, you must be aware that the Division for Medical Assistance is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Division 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 Division for Medical Assistance, within the Bureau for Social Insurance of the Department for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program The Division for Medical Assistance makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been rendered to eligible recipients.

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

C. Advisory Council

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

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

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

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

D. Policy

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

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

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

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

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

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

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

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.

When a Medicaid eligible patient must return to the clinic for completion of an Initial/Annual pap smear, no claim is to be submitted for this visit. This would be considered a completion of the Initial/Annual. Patient record documentation should reflect the reason for the return visit.

The same principle as above applies to the Medicaid patient who must return and also must receive supplies. In view of the fact that the contraceptive method is considered a part of the reimbursement for the first visit, no additional claim may be submitted. The Medicaid patient must not be assessed a fee nor shall the Medicaid program be billed for the supplies.

Medicaid policy states that the Family Planning clinic is required to diagnose and treat or refer patients with vaginal infections. The medication is to be provided at the time of the visit. No other claim may be submitted if the patient returns for the sole

purpose of picking up the medication. The Medicaid patient must not be assessed a fee nor shall the Medicaid program be billed for the medication issued. In the event that physician prescribes a medication not routinely provided by the clinic, the patient may be given a prescription to take to the pharmacy or the patient may be referred to her private physician.

If a Medicaid recipient comes to the clinic for a free pregnancy test and counseling on the results, no claim shall be submitted to the Medicaid program.

Exception: If a patient receive contraceptive supplies and counseling in addition to a pregnancy test and counseling, a claim for a supply/counseling visit may be submitted.

If an ARNP requests the Medicaid patient to return to the clinic to see the physician due to a suspected problem, a bill may be submitted for both visits. The visit by the physician would be billed using the appropriate procedure code for a follow-up visit by the physician. The charge must be entered on the MAP-4.

Return visits for the Medicaid patient receiving counseling due to an abnormal pap smear are payable. The counseling code would be used to reflect the medical professional.

A post-diaphragm fitting check for a Medicaid patient is payable as a follow-up visit. The charge must be entered on the MAP-4.

A Medicaid patient's post partum visit is payable. The actual type of visit to be billed will be determined by the following:

1. New patient - Bill an Initial

2. Established patient - Determine the length of time since the last visit. If it has been at least nine months, bill an Annual. If it has been less than nine months, bill a follow-up. Determine at what point the nine months will lapse and reschedule the patient for an Annual.

Split billing of the Initial or Annual is not acceptable to the Medicaid program.

In the event a recipient comes to the clinic shortly before her actual scheduled Initial or Annual and any services exceeding those required for a counseling/supply visit are provided, for example, lab work, no claim for this visit may be submitted. These services, including the lab work, are considered part of the Initial or Annual and this is considered preliminary work-up for the Initial or Annual.

If; however, the patient visits the clinic shortly before the scheduled Initial or Annual and the only service that is provided is Counseling/ Supply, a claim may be submitted for that visit.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

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

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

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

(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,

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

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

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

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

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

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

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

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

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

(d) Whoever knowingly and willfully--
(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or
(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--
(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
(B) as a requirement for the patient's continued stay in such a facility,
when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,
shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

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

G. Kentucky Patient Access and Care System (KenPAC)

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

Under KenPAC the following service categories must be either provided by the primary physician or referred by the primary physician in order to be reimbursed by Kentucky Medicaid.

-Physician (excludes KMAP recognized Ophthalmologists, Psychiatrists, and OB/GYN provided obstetrical services)
-Hospital (Inpatient and Outpatient)
-Laboratory Services
-Nurse Anesthetists
-Rural Health Clinic Services
-Home Health
-Primary Care Centers
-Ambulatory Surgical Centers

Family Planning Clinic Services are exempt from the required referral and may be obtained at the option of the KenPAC recipient in the usual manner.

In the event you make a referral to one of the service elements listed above, you are to contact the primary care physician for his/her Medicaid provider number. This number is <u>not</u> to be entered on the billing form. The acquisition of this number is solely for the use by the medical professional to whom the referral is being made.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

Provider

As the size and spacing of families so profoundly relates to the physical and emotional health of individuals and families, it is the objective of the Family Planning Services element to provide each recipient of reproductive age with complete information regarding available contraceptive methods and infertility services, and to assure that each recipient receives the devices and services required.

Any family planning agency meeting the participation requirements outlined herein is eligible to submit to the KMAP appropriate forms as designated on page 3.20. Determination of provider eligibility and certification for participation will be accomplished by the Department for Medicaid Services.

A. Administration

1. The family planning agency shall name an administrative director, who shall be responsible for assuring that the requirements for participation are met and that the procedures established by the Program are carried out. The family planning agency shall have on its staff a physician, duly licensed, who shall be responsible for development and implementation of the agency's medical policies and procedures and shall generally supervise and evaluate the medical components of the ongoing program.

2. The participating agency shall keep on file administrative policies, detailing the agency's organizational structure, with lists of all personnel, their position classifications, and specific areas of responsibility assigned to each. Also included shall be a description of services rendered in the agency, with explicit guidelines for referral and follow-up services, a description of medical records kept, and a list of equipment and supplies maintained by the agency.

3. The family planning clinic can bill only for services actually performed.

4. The clinic should select the HCPC-Local code which most accurately and completely describes the actual service performed.

5. The charge made to the KMAP should be the same charge made for comparable services provided to any party or payor.

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

B. Staff

1. Director -- The agency shall have an administrative director, who shall be responsible for assuring that the requirements for participation are met and that the procedures established by the Program are carried out.

2. Physician -- The agency shall have at least one physician, who has a current, valid license to practice at the time the medical services or procedures are performed; who shall be responsible for all medical aspects of the program, and who shall perform direct medical services as indicated.

3. Nurse -- The agency shall have at least one professional registered nurse, who shall function under the supervision of the physician and the administrative director to assure the efficient provision of required services in accordance with health care standards described herein.

4. Other Staff -- The agency shall have the necessary supportive staff, paramedical and clerical, to assure the performance of services outlined herein.

   All staff shall be trained and their services limited to their area of competence and in accordance with the professional practice acts governing the health disciplines.

NOTE: Reimbursement for services rendered by an Advanced Registered Nurse Practitioner (ARNP) will be made to participating agencies providing the Guidelines for the Utilization of the Advanced Registered Nurse Practitioner are followed. (See Appendix VII-F)

C. Available Services

The family planning agency shall make available to each recipient at least the following services. When a service cannot be provided by the agency itself, the agency shall be responsible for referral to and acceptance of the recipient by an appropriate source.

1. Initial Clinic Visit

a. Complete Medical History--A complete medical history shall be obtained and recorded, along with relevant family history. The history 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.

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.

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 A VENDOR CAN BILL FOR AN INITIAL EXAMINATION.

2. Revisits by Contraceptive Patients--Scheduled

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 not less frequently than annually. Revisits scheduled at 3 month intervals are not required unless recommended by the physician and/or medically indicated.

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

b. I.U.D. Recipients shall return to the clinic not later than three months following insertion of the device, at which time at least 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

Revisits scheduled at 3 month intervals are not required unless recommended and/or medically 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.

The KMAP can make reimbursement for counseling and/or supply visits rendered to males, providing the recipients were eligible at the time the services were rendered.

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.

c. Repeat of initial laboratory and clinical procedures detailed in Section C.1.c., page 3.04.

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.

4. Follow-Up Services

Any recipient who fails to keep an appointment for a scheduled contraceptive visit, or who discontinues use of the prescribed contraceptive method, shall be contacted by agency personnel and the reason determined. Encouragement and any possible aid shall be given to the recipient to insure continued enrollment in the agency's program. The KMAP cannot reimburse the vendor for counseling visits outside a clinic setting.

5. Revisits by Recipient -- Unscheduled.

Recipients shall be encouraged to return to the clinic whenever they have specific problems related to the contraceptive method or wish additional guidance, service, or contraceptive supplies.

6. Voluntary Sterilization

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 registered nurse, or the ARNP following those services required during any initial contraceptive visit to the clinic, 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.

SECTION III - CONDITIONS OF PARTICIPATION

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.

If the recipient decides to be sterilized, the clinic shall be responsible for the referral to and acceptance of the recipient by the proper medical source. In addition, the clinic shall:

a. Inform the recipient that in accordance with new Federal regulations, a 30 day waiting period is required from the time the Consent to Sterilization Form is signed.

b. Provide information and instructions concerning need for follow-up, particularly for males.

c. Provide all males undergoing vasectomy with appropriate post-operative semen analysis.

If the recipient is married and resides with the spouse, the agency may also wish to obtain the written informed consent of the spouse.

NOTE: Family Planning Clinics are no longer required to obtain the patient's signature on a consent form to attest to counseling. Clinics are, however, required to document, in detail, all pertinent counseling and referral information.

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.

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. Inpatient Services

Provision shall be made for inpatient care of recipients whose hospitalization is necessitated by complications arising from contraceptive services provided. The agency shall have on file a formal, written affiliation agreement with at least one area hospital.

11. 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.

12. 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.

D. Supplies

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

1. Oral contraceptives
2. Intrauterine devices
3. Diaphragms
4. Foams
5. Thermometers for rhythm method
6. Jellies and Creams
7. Condoms

E. Medical Records

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

1. Initial and interim histories -- medical, psychiatric, and social.

2. Record of initial and interim physical examinations.

3. All laboratory reports.

SECTION III - CONDITIONS OF PARTICIPATION

G. 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.

H. Physical Facilities

The agency shall be located in an area that is constructed, equipped and maintained to insure the safety of the recipients and provide a functional, sanitary environment. The area utilized by the family planning clinic must be adequate in space and design to provide non-surgical family planning services specified in Section IV, with setting and atmosphere to insure respect for the privacy and dignity of individuals during medical examinations, counseling, and interviews.

I. Equipment

The agency shall have the necessary equipment to provide the services detailed in Section III. C. Available Services.

J. Termination of Participation

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

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

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

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

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

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

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

SECTION IV - SERVICES COVERED

IV. SERVICES COVERED

The KMAP will make payment to participating family planning agencies for required services provided to all eligible Title XIX recipients. These services are to be billed under the following categories.

A. Initial Clinic Visit

The initial clinic visit shall be billed to the Program for services provided a new recipient during his/her first visit to the agency. The recipient must be examined by the physician or ARNP, with all services listed under III.C.1. being rendered. When the recipient requests other specifically covered services, such as voluntary sterilization or infertility services, additional requirements detailed in the appropriate section of III.C. Available Services must also be met.

1. Program payment for the visit shall be considered payment in full for the following. Any expenses incurred by the agency in provision of these services or items, such as laboratory services rendered by another provider, shall be considered the responsibility of the agency, and neither the Program, the recipient, nor any other source may be billed additional amounts for these services or items.

   a. All services, including history, physical examination, laboratory procedures and counseling required under III.C.1. Initial Clinic Visit.

   b. All supplies and materials used during the visit.

c. All medications and contraceptive devices or supplies dispensed to the recipient.

d. Diagnosis and treatment or referral for treatment of vaginal infection.

e. Pregnancy testing.

f. Sterilization and infertility counseling.

g. Referral services.

B. Annual Clinic Visit

Payment will be made for an annual clinic visit, during which the recipient must be examined by the physician or ARNP. This visit shall include all services required under Section III.C.3. Annual Visits. If the recipient should request a sterilization or other specifically covered service, any additional requirements applicable to that service must also be met.

C. Follow-up Visit With Pelvic Examination

The follow-up visit with pelvic examination is to be billed for any visit to the agency other than the initial or annual visit, during which the recipient is seen by the physician or ARNP and receives a pelvic examination. Such visits may be follow-up visits routinely scheduled for a given contraceptive method, or may be initiated by the recipient because of some contraception-related medical problem.

D. Follow-Up Visit Without Pelvic Examination

The followup visit without pelvic examination is to be billed for any visit to the agency during which the recipient is examined by the physician or ARNP but does not receive a pelvic examination. Such visits may be follow-up visits routinely scheduled for a given contraceptive method, or may be initiated by recipients because of contraception-related problems which require examination by a physician.

E. Counseling Visit

The counseling visit is to be billed for any clinic visit or follow-up visit during which counseling services are rendered the recipient by the physician or by other agency staff. Such visits may be follow-up visits routinely scheduled for a given contraceptive method, or may be initiated by recipients whose contraception-related problems do not require examination by a physician.

The counseling visit may involve taking of an interim medical history, blood pressure check, and other such services rendered by agency paramedical staff. It may also be billed when the recipient requires additional information from the physician, ARNP, or paramedical staff regarding the chosen contraceptive method, or simply needs assurance.

Payment for a counseling visit may not be requested when the recipient visits the agency for the sole purpose of obtaining contraceptive supplies, and has no contraception-related problems which require a substantial amount of staff time.

The KMAP cannot make reimbursement for counseling services rendered outside a clinic setting.

SECTION IV - SERVICES COVERED

F. Supply Only Visit

The supply only visit is to be billed when the recipient visits the agency for the sole purpose of obtaining contraceptive supplies. Program payment for the supplies dispensed is to be considered payment in full for those supplies.

NOTE: Dispensing of any family planning supplies must be in accordance with all applicable laws and regulations.

If the recipient visits the agency for the purpose of obtaining supplies, but has a contraception-related problem which requires the physician or ARNP's attention or considerable counseling services from other agency staff, the appropriate type of visit, rather than a "Supply Only Visit" should be billed.

G. Contraceptive Emergency Services

If emergencies related to contraceptive services occur when the clinic is not in session, the Program will make payment to an appropriate participating medical provider for the services and/or items required, within the limitations of the particular Program element.

H. Inpatient Services

If a clinic recipient requires inpatient care as a result of complications arising from contraceptive services provided by the clinic, the Program will make payment for that care within the limitations of the hospital inpatient element, contingent on the recipient's continuing technical eligibility.

SECTION IV - SERVICES COVERED

I. Referrals

The Program will make payment to the appropriate medical provider for covered services provided on referral from the family planning agency, within the scope and policies of the Program.

J. Limitations of Covered Services

1. Initial Visit

The Initial Visit is to be billed when a patient visits the clinic for the first time. The patient should be seen annually thereafter. Therefore, the Initial Visit is limited to one, per patient, per clinic.

2. Multiple Services

Family Planning Services are limited to one service per date of service. More than one clinic visit is not allowed on the same day.

3. Annual Visit

The Annual Family Planning Clinic Visit is limited to one per patient per nine months. There must be at least nine months between the patient's Initial Visit and the first Annual Visit and at least nine months between Annual Visits.

4. Limits on Birth Control Medication

The Department for Medicaid Services has adopted the following policy with regard to Program coverage for birth control medication. This policy applies to those patients who must present a prescription for Birth Control medications that are not routinely covered by the clinic.

a. The Program will reimburse for no more than one prescription per day for birth control medication per Medicaid recipient.

b. The Program will reimburse for no more than a total of 13 prescriptions in any calendar year for a given Medicaid patient.

c. Through the Program's Drug Utilization Review (DUR) subsystem, an in-depth review will be accomplished in any instance where a Medicaid recipient is receiving more than the appropriate amount of birth control medication (i.e, exceeds a thirty (30) day supply in a thirty (30) day period). The purpose of the review will be to determine the reason of the excess supply, and to recommend appropriate action to address the excess supply.

SPECIAL NOTE: NON-COVERED SERVICES

Counseling visits rendered outside a clinic setting

B. 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.

C. 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.

2. Identification of Third Party Resources

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

SECTION V - REIMBURSEMENT

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

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

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

3. Billing Instructions for Claims Involving Third Party Resources

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

Exceptions:

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

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

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

*A letter from the provider indicating that he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

SECTION VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General Billing Information

The Health Insurance Claim Form (HCFA-1500) should be used to bill for services rendered to eligible KMAP recipients by a participating Family Planning Agency. Typing of the invoice form is strongly urged, since an invoice cannot be processed and paid unless the information supplied is complete and legible.

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

Invoices should be mailed to:

EDS
P.O. Box 2018
Frankfort, Kentucky 40602

B. Procedural Coding

On May 1, 1985, KMAP adopted for procedural coding purpose, the HCFA Common Procedural Coding System (HCPCS).

C. Completion of HCFA-1500

An example of a HCFA-1500 is shown in Appendix VII. Instructions for the proper completion of this form are presented below.

A supply of HCFA-1500 may be obtained by contacting:

Blue Cross/Blue Shield of Kentucky
9901 Linn Station Road
Louisville, Kentucky 40223

SECTION VI - COMPLETION OF INVOICE FORM

IMPORTANT: The patient's Kentucky Medical Assistance Identification Card should 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. You cannot be paid for services rendered to an ineligible person.

Program payment will be made if the patient is eligible at the time the service is rendered and if the claims for services are received by the KMAP within 1 year (12 months) of the date of service.

Block No.	Description

1. RECIPIENT'S NAME:

Enter the recipient's last name, first name, and middle initial as indicated on the MAID Card.

6. INSURED'S ID NUMBER:

Enter the recipient's 10-digit MAID Number exactly as it appears on the current MAID Card.

9. OTHER HEALTH INSURANCE, IF APPLICABLE:

Complete if the recipient has any other kind of health insurance applicable to this service, other than Medicare. Enter the name and address of the insurer and the policy number. The amount paid by the insurance company should be listed in Block #28. Private insurance must be billed prior to billing the KMAP.

19. REFERRING PHYSICIAN:

Required for referred KenPAC and Lock-In recipients. Enter the 8-digit KMAP provider number of the referring KenPAC or Lock-In provider. Enter only one referring KenPAC provider number.

23A. DIAGNOSIS OF NATURE OF ILLNESS:

Enter the ICD-9-CM diagnosis code for the diagnosis that was treated.

SECTION VI - COMPLETION OF INVOICE FORM

Block No. Description

24A. DATE OF SERVICE:

Enter the date of service in numeric month, day, year order.

24B. PLACE OF SERVICE:

Use the codes on the back of the billing form which identify where the service was performed. The codes are:

1 Inpatient Hospital
2 Outpatient Hospital
3 Doctor's Office
4 Patient's Home
5 Day Care Facility
6 Night Care Facility
7 Nursing Home
8 Skilled Nursing Facility
9 Ambulance
0 Other Location

A Independent Laboratory
B Ambulatory Surgical Center
C Residential Treatment Center
D Specialized Treatment Facility
E Comprehensive Outpatient Rehabilitation Facility
F Independent Kidney Disease Treatment Center

24C. PROCEDURE CODE:

Enter the appropriate procedure code for the service that was performed.

Family Planning providers will enter the 8-digit provider number of the professional rendering the service in description area of 24C, if different than the billing provider listed in field 31 on the claim form.

24D. DIAGNOSIS CODE:

Transfer a 1, 2, or 3 from item 23.A to indicate which diagnosis is being treated. DO NOT enter the actual ICD-9-CM code in this block.

SECTION VI - COMPLETION OF INVOICE FORM

24E. CHARGES:

Enter the usual and customary charges for each procedure.

24F. DAYS/UNITS:

Enter the number of days being billed or the number of times that procedure was performed.

24H. LEAVE BLANK:

25. SIGNATURE OF PROVIDER/PROVIDER REPRESENTATIVE:

The provider's signature or a delegated representative must sign and date the claim form. Stamped signatures are not acceptable.

DATE:

Enter in numeric format the date the claim was completed and sent to EDS for processing.

27. TOTAL CHARGES:

Enter the total charges from all lines of the claim.

28. AMOUNT PAID:

Required if private insurance payment was made.

29. BALANCE DUE:

Required if private insurance payment was made. Subtract the payment from the total charges and enter the balance due.

SECTION VI - COMPLETION OF INVOICE FORM

31. PROVIDER NAME, ADDRESS, AND PROVIDER NUMBER:

Enter the provider's name and address.

ID NO.:

Enter the provider's KMAP 8-digit provider number.

36. CLAIM NO.:

Enter the claim number, if different from the pre-printed number on the claim form. EDS will return the first seven digits as an invoice number on the remittance statement.

SECTION VII - REMITTANCE STATEMENT

VII. REMITTANCE STATEMENT

A. General

The EDS Federal Corporation Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS Federal Corporation 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 Federal Corporation 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 Federal 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 VIII-A. This section lists all of those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR FAMILY PLANNING SERVICES

ITEM	
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 Federal Corporation
CLAIM SVC DATE	The earliest and latest dates of service as shown on the claim form
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form
CHARGES NOT COVRD	Any portion of the provider's billed charges that are not being paid, (examples: rejected line item, reduction in billed amount to allowed charge)

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 this 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
PS	Place of service code depicting the location of the rendered service
PROC	The HCPCS Procedure for the line item.
QTY	The number of procedures/supply for that line item charge
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item
LINE ITEM PMT	The amount being paid by the Medicaid program to the provider for a particular line item
EOB	Explanation of benefit code which identifies the payment process used to pay the line item

C. Section II - Denied Claims

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

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

SECTION VII - REMITTANCE STATEMENT

D. Section III - Claims in Process

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

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix VIII-D) lists those claims which have been received by EDS Federal 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)
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 VIII-E).

SECTION VIII - GENERAL INFORMATION - EDS FEDERAL

A. Correspondence Forms Instructions

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

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
Refund	1. Refund Check 2. Photocopy of the applicable portion of the R/A in question 3. 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

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 the date a claim is submitted to the insurance company, 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

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:

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

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.

Field Number	Description
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.

FAMILY PLANNING SERVICES
APPENDIX

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Ambulatory Surgical Center Services

Medicaid covers medically necessary services performed in ambulatory surgical centers.

Birthing Center Services

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

Dental Services

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

Family Planning Services

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

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

Hearing Services

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Home Health Services

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

Hospital Services

Inpatient Services

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

Outpatient Services

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

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

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

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

Intermediate Care Facility Services

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

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

*Need for the intermediate level of care must be certified by a PRO.

**Need for the ICF/MR/DD level of care must be certified by the Department for Medicaid Services.

Mental Hospital Services

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Community Mental Health Center Services

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

Outpatient Services
Partial Hospitalization
Emergency Services
Inpatient Services
Personal Care Home Visits

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

Nurse Anesthetist Services

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

Nurse Midwife Services

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

Pharmacy Services

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Pharmacy Services (Continued)

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

Physician Services

Covered services include:

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

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

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, contact lenses, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Physician Services (Continued)

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

- Ova and Parasites (feces)
- Smear for Bacteria, stained
- Throat Cultures (Screening)
- Red Blood Count
- Hemoglobin
- White Blood Count
- Differential Count
- Bleeding Time
- Electrolytes
- Glucose Tolerance
- Skin Tests for:
  - Histoplasmosis
  - Tuberculosis
  - Coccidioidomycosis
  - Mumps
  - Brucella
- Complete Blood Count
- Hematocrit
- Prothrombin Time
- Sedimentation Rate
- Glucose (Blood)
- Blood Urea Nitrogen (BUN)
- Uric Acid
- Thyroid Profile
- Platelet Count
- Urine Analysis
- Creatinine

Podiatry Services

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

Primary Care Services

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Renal Dialysis Center Services

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

Rural Health Clinic Services

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

Screening Services

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

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

Transportation Services

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Vision Services

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

SPECIAL PROGRAMS

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

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

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

HOSPICE:

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

ELIGIBILITY INFORMATION

Programs

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

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

Refugee Resettlement Programs

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

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

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

ELIGIBILITY INFORMATION

MAID Cards

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

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

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

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

Verifying Eligibility

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

The Division of Medical Assistance, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

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

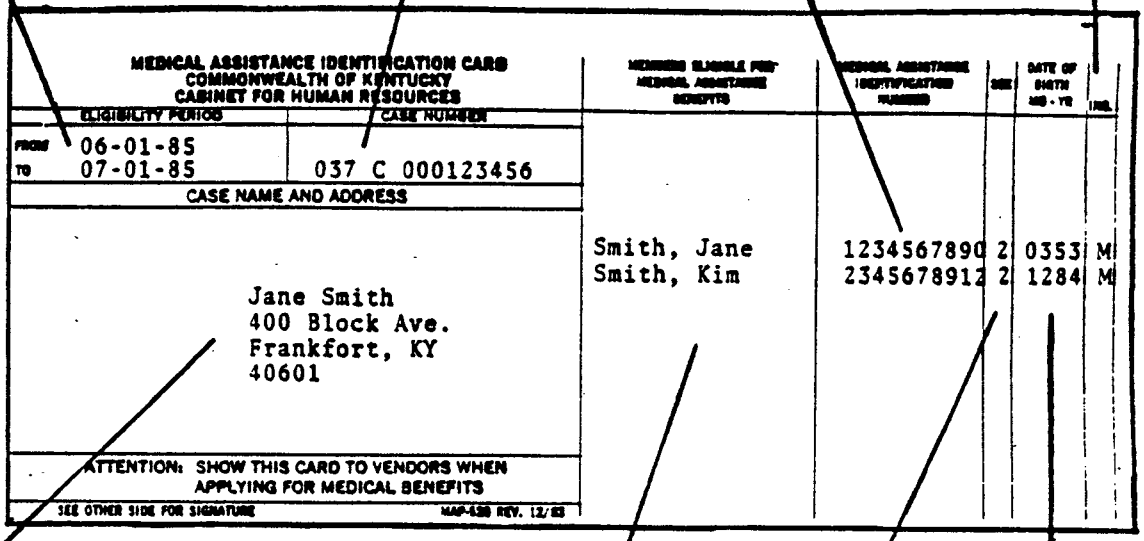
(FRONT OF CARD)

Eligibility Period is the month, day and year of KMAP eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

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

Medical Insurance Code indicates type of insurance coverage.-

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



MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD	CASE NUMBER
FROM 06-01-85 TO 07-01-85	037 C 000123456

CASE NAME AND ADDRESS

Jane Smith
400 Block Ave.
Frankfort, KY
40601

MEMBERS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS | MEDICAL ASSISTANCE IDENTIFICATION NUMBER | SEX | DATE OF BIRTH MO - YR | INS.

Smith, Jane 1234567890 2 0353 M
Smith, Kim 2345678912 2 1284 M

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

SEE OTHER SIDE FOR SIGNATURE MAP-638 REV. 12/83

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

For K.M.A.P. Statistical Purposes

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

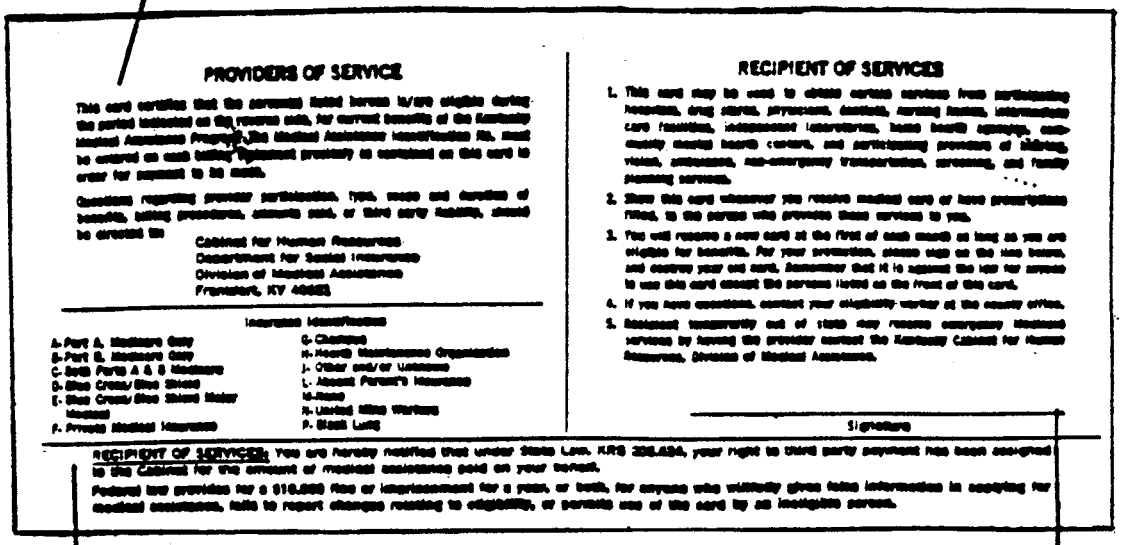
Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

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

(BACK OF CARD)

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



PROVIDERS OF SERVICE

RECIPIENT OF SERVICES

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

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

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

(BACK OF CARD)

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

ATTENTION:

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

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person, if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In Coordinator, by calling 502-564-5560.

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

Insurance Identification

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

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

Signature of Recipient or Representative — Date

RECIPIENT OF SERVICES

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

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

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

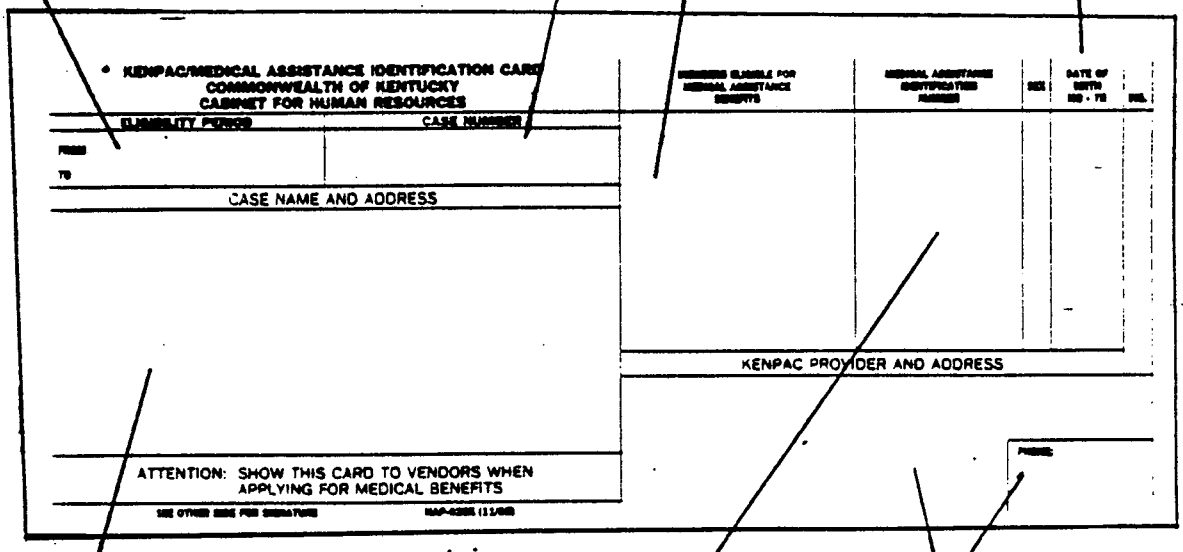
(FRONT OF CARD)

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

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

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

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



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

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

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

APPENDIX II-C

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

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

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

PROVIDERS OF SERVICE

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

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

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, Kentucky 40621

Insurance Identification

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

RECIPIENT OF SERVICES

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

Signature

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

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

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

Recipient's signature is not required.

HW-343 (Rev. 3/82)

P.L. 92-603 LAWS OF 92nd CONG.--2nd SESS. (As Amended)

PENALTIES

Section 1909. (a) Whoever--

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

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

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

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

shall (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,

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

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

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

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

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

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

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

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

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

(d) Whoever knowingly and willfully--

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

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

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

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

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

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

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____

2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)

3. _____ _____ _____
City State Zip Code

4. _____
Area Code Telephone Number

5. _____
Pay to, In Care of, Attention, etc. (If different from above)

6. _____
Pay to Address (If different from above)

7. Federal Employer ID Number: _____

8. Social Security Number: _____

9. License Number: _____

10. Licensing Board (If Applicable): _____

11. Original License Date: _____

12. KMAP Provider Number (If Known): _____

13. Medicare Provider Number (If Applicable): _____

14. Provider Type of Practice Organization:

☐ Corporation (Public) ☐ Individual Practice ☐ Hospital-Based Physician

☐ Corporation (Private) ☐ Partnership ☐ Group Practice

☐ Health Maintenance Organization ☐ Profit ☐ Non-Profit

15. If group practice, Number of Providers in Group (specify provider type):

_____

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

Name:_____

Address:_____

_____

Telephone Number:_____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership, name and address of Partners:

_____

_____

_____

_____

_____

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

19. Physician/Professional Specialty:

1st_____

2nd_____

3rd_____

20. Physician/Professional Specialty Certification:

1st_____

2nd_____

3rd_____

31. Management Firm (If Applicable)

Name: _____

Address: _____

32. Lessor (If Applicable)

Name: _____

Address: _____

33. Distribution of Beds in Facility -- Complete for all levels of care

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

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

Name	Address	Percent of Ownership

35. Institutional Review Committee Members (If Applicable):

_____

_____

_____

_____

_____

36. Providers of Transportation Services:

No. of Ambulances in Operation:_____ No. of Wheelchair Vans in Operation:_____
Total No. of Employees:_____ (Enclose list of names, ages, experience & training.)
Current Rates:

A. Basic Rate $_____ (Includes up to _____miles.)
B. Per Mile $_____
C. Oxygen $_____
D. Extra Patient $_____
E. Other _____ $_____

37. Provider Authorized Signature:_____

Name:_____

Title:_____

Date:_____

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

I. Agreement of Participation

After endorsement by the _____ for the

_____ to participate in the

KMAP Family Planning Program, and prior to implementation of the Program, an Agreement of Participation and Statement of Agency Authorization, if applicable, signed by the Appointing Authority, will be submitted to the Director of the Kentucky Medical Assistance Program, Bureau for Social Insurance.

II. Governing Body

The _____ is to serve as the governing body legally responsible for the conduct of the KMAP Family Planning Program.

III. Medical and/or Administrative Director

_____ is to serve as Director and will be responsible for the Family Planning Program and the establishment of administrative policies.

IV. Staff

1. _____ (Nurse) is designated to be responsible for the implementation of the Family Planning Program.

2. The following _____ personnel will participate in the family planning clinics on a regular basis with changes to be made as necessary:

   (List personnel, position classification, and description of assigned duties.)

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

Professional staff will assume responsibility for the technical training of paraprofessional clinic staff and will provide necessary supervision for delegated activities.

3. If physician attendance is deemed necessary, this will be provided by _____, M.D.

V. Available Services

The KMAP Family Planning Program will provide, but not be limited to, the following basic services for eligible recipients:

1. Initial Clinic Visit
2. Revisits by Contraceptive Patients -- Scheduled
3. Annual Visits
4. Follow-up Services
5. Revisits by Patient -- Unscheduled
6. Voluntary Sterilization Counseling
7. Infertility Services
8. Vaginal Infections (Diagnosis and Treatment or Referral)
9. Emergency Services
10. Inpatient Services -- (Affiliation Agreement Only)
11. Pregnancy Testing
12. Referrals

The "Kentucky Medical Assistance Program Policies and Procedures for Family Planning Services" will be used as reference for techniques and procedures.

VI. Referral Responsibility

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.

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

b. For pregnancy-related services when appropriate.

c. For social case work not appropriately handled by agency personnel.

VII. Follow-up

When the physician's referral has been completed and returned to the agency, follow-up services will be provided as indicated.

VIII. Equipment and Supplies

Participating clinics shall have the equipment and supplies necessary to provide the services detailed in Section II-C, Available Services --KMAP Policies and Procedures for Family Planning Services."

IX. Program Implementation

1. All Services will be provided as outlined in the KMAP Policies and Procedures Manual.

2. The participating agency will be responsible for notifying eligible recipients regarding appointments or schedules.

3. Clinics will be scheduled in such a manner so as to avoid undue waiting for the patient.

4. Clinic procedures will be developed as deemed advisable by the governing body of the agency.

5. Each member of the nursing staff will be thoroughly familiar with clinic routines to assure continuity of services in case of staff absences.

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

X. Medical Records

The _____ shall maintain the required Kentucky Medical Assistance records for each recipient with all entries kept current, dated and signed.

1. Patient History (Medical, Psychiatric and Social)
2. Physical Examination Records
3. Laboratory Report
4. Description of Visits
5. Referral Records
6. Follow-up Records
7. Written consent if a patient is to be sterilized

In addition, appropriate records will be initiated, or existing records used, for each recipient. Results of tests and other services will be recorded as indicated.

1. Retention

   All records of recipients will be retained for five (5) years.

2. Availability

   All medical and financial records, pertaining to services rendered in the KMAP Family Planning Program, will be made available for review and audit by authorized representatives of the Kentucky Medical Assistance Program.

XI. Policy Revision

Administrative policies of the KMAP Family Planning Services Program will be revised as necessary.

HCPCS Local Family Planning Services
Procedure/Supply Codes

	Physician						
Type of Contraceptive Dispensed - This Visit	Intake or Initial Visit	Medical Revisit or Follow-up Visit With Pelvic Examination	Medical Revisit or Follow-up Visit Without Pelvic Exam.	Counseling Visit	Counseling with a 3 Mo. Supply	Counseling with a 6 mo. Supply	Annual Revisit and Examination
Birth Control Pills	X1110	X1210	X1310	X1410	X1495	X1499	X1510
Intrauterine Device	X1120	X1220	X1320	X1420	-----	-----	X1520
Diaphram	X1130	X1230	X1330	X1430	-----	-----	X1530
Foam/Condoms	X1140	X1240	X1340	X1440	-----	-----	X1540
Rhythm	X1150	X1250	X1350	X1450	-----	-----	X1550
Injection	X1170	X1270	X1370	X1470	-----	-----	X1570
Referral for Sterilization	X1180	X1280	X1380	X1480	-----	-----	X1580
Other(Specify)	X1190	X1290	X1390	X1490	-----	-----	X1590
None Dispensed This Visit	X1100	X1200	X1300	X1400	-----	-----	X1500

HCPCS Local Family Planning Services
Procedure/Supply Codes

Advanced Registered Nurse Practitioner

Type of Contraceptive Dispensed - This Visit	Intake or Initial Visit	Medical Revisit or Follow-up Visit With Pelvic Examination	Medical Revisit or Follow-up Visit Without Pelvic Exam.	Counseling Visit	Counseling Visit with a 3 Mo. Supply	Counseling Visit with a 6 Mo. Supply	Annual Revisit and Examination
Birth Control Pills	X4110	X4210	X4310	X4410	X4495	X4499	X4510
Intrauterine Device	X4120	X4220	X4320	X4420	-----	-----	X4520
Diaphram	X4130	X4230	X4330	X4430	-----	-----	X4530
Foam/Condoms	X4140	X4240	X4340	X4440	-----	-----	X4540
Rhythm	X4150	X4250	X4350	X4450	-----	-----	X4550
Injection	X4170	X4270	X4370	X4470	-----	-----	X4570
Referral for Sterilization	X4180	X4280	X4380	X4480	-----	-----	X4580
Other(Specify)	X4190	X4290	X4390	X4490	-----	-----	X4590
None Dispensed This Visit	X4100	X4200	X4300	X4400	-----	-----	X4500

HCPCS Local Family Planning Services Procedure/Supply Codes

Type of Contraceptive Dispensed - This Visit	Nurse				Other Paramedical Agency Staff			
	Counseling Visit	Counseling Visit With a 3 Mo. Supply	Counseling Visit With a 6 Mo. Supply	Supply Only	Counseling Visit	Counseling Visit With a 3 Mo. Supply	Counseling Visit With a 6 Mo. Supply	Supply Only
Birth Control Pills	X2410	X2495	X2499	-----	X3410	X3495	X3499	-----
Intrauterine Device	-----	-----	-----	-----	-----	-----	-----	-----
Diaphram	-----	-----	-----	-----	-----	-----	-----	-----
Foam/Condoms	X2440	-----	-----	X0024	X3440	-----	-----	X0034
Rhythm	X2450	-----	-----	X0025	X3450	-----	-----	X0035
Injection	-----	-----	-----	-----	-----	-----	-----	-----
Referral for Sterilization	X2480	-----	-----	-----	-----	-----	-----	-----
Other(Specify)	X2490	-----	-----	X0029	X3490	-----	-----	X0039
None Dispensed This Visit	X2400	-----	-----	-----	X3400	-----	-----	-----

[redacted]

APPENDIX VII

FORM APPROVED OMB NO. 0938-00

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

Form HCFA-1500 (1-84) Form OWCP-1500

Form CHAMPUS-501 Form RRB-1500

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN) ☐ BLUE SHIELD

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

2 PATIENT'S DATE OF BIRTH

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

5 PATIENT'S SEX

MALE ☐ ☐ FEMALE

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS)

7 PATIENT'S RELATIONSHIP TO INSURED

SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED'S EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO

A. PATIENT'S EMPLOYMENT

YES ☐ ☐ NO

B ACCIDENT

AUTO ☐ ☐ OTHER

INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11a CHAMPUS SPONSOR'S

STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED

BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES

16a IF EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (OR PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?

YES ☐ ☐ NO CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS (1, 2, 3, ETC. OR DX CODE)

1

2

3

4

B

EPSDT YES ☐ ☐ NO

FAMILY PLANNING YES ☐ ☐ NO

PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM TO	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* T.O.S.	H LEAVE BLANK

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)

DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO

27 TOTAL CHARGE

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO.

31 PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

32 YOUR PATIENT'S ACCOUNT NO.

33 YOUR EMPLOYER I.D. NO.

I.D. NO.

34.

35. MAKE PAYMENT TO SUBSCRIBER ☐ PHYSICIAN ☐

36. CLAIM NO. 547544

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK REMARKS.

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

HEALTH PLAN COPY

PLACE OF SERVICE CODES

1 - (IH)	-	Inpatient Hospital
2 - (OH)	-	Outpatient Hospital
3 - (O)	-	Doctor's Office
4 - (H)	-	Patient's Home
5 -	-	Day Care Facility (PSY)
6 -	-	Night Care Facility (PSY)
7 - (NH)	-	Nursing Home
8 - (SNF)	-	Skilled Nursing Facility
9 -	-	Ambulance
0 - (OL)	-	Other Locations
A - (IL)	-	Independent Laboratory
B - (ASC)	-	Ambulatory Surgical Center
C - (RTC)	-	Residential Treatment Center
D - (STF)	-	Specialized Treatment Facility
E - (COR)	-	Comprehensive Outpatient Rehabilitation Facility
F - (KDC)	-	Independent Kidney Disease Treatment Center

Registration Notification for Advanced Registered Nurse Practitioner

This is to certify that _____ has been certified by _____ (professional organization) to practice in the expanded role of an Advanced Registered Nurse Practitioner (ARNP) in a Family Planning Clinic.

The services provided by _____ (ARNP) in _____ (agency) will be in accordance with the Guidelines for Advanced Registered Nurse Practitioner in a Family Planning Clinic and the Policies and Procedures set forth in the Kentucky Medical Assistance Family Planning Services Manual.

_____
(Physician)

_____
(Advanced Registered Nurse Practitioner)

_____
(Registration #)

_____
(Date)

GUIDELINES FOR THE UTILIZATION OF THE OB/GYN ADVANCED REGISTERED NURSE PRACTITIONER IN A FAMILY PLANNING CLINIC (Cont.)

Policy and Guidelines on Utilization of ARNPs in Family Planning Clinics:

The following guidelines have been developed for the use of community health agencies to effectively utilize the ARNP in providing family planning services. Those agencies receiving Federal monies for the implementation of Family Planning Programs are expected to follow these guidelines.

Prior to providing services within clinics Federally funded for family planning and annually by June 1 thereafter, each Advanced Registered Nurse Practitioner must submit to the Division for Maternal and Child Health Services, Family Planning Program, a copy of his/her current Kentucky registration as an ARNP.

A copy of the medical protocol agreed on by the ARNP and collaborating physician must be submitted to the Division for Maternal and Child Health Services, Family Planning Program. Thereafter, only changes in the protocol must be submitted. The protocol must be comprehensive in nature and be applicable to all normal situations which the Nurse Practitioner may encounter in the Family Planning Clinic. Specific instructions as to oral contraceptive recommended in each situation are to be outlined. Management of minor gynecological problems must be outlined and be specific for the problem.

The medical protocol must be reviewed and updated at least annually by the ARNP and the physician who authorizes her to practice in the expanded role.

Each medical record indicating ARNP services reflecting the expanded role, must be reviewed and co-signed by the collaborating physician. Physician emergency consultation must be readily available for the ARNP providing services in Family Planning Clinics.

GUIDELINES FOR THE UTILIZATION OF THE OB/GYN ADVANCED REGISTERED NURSE PRACTITIONER IN A FAMILY PLANNING CLINIC

Legal Aspects:

The Advanced Registered Nurse Practitioner functions within the framework of the Nurse Practice Act. This act was revised in 1978 and permits the registration of Advanced Registered Nurse Practitioners (KRS 314). The Kentucky Board of Nursing regulation (201 KAR 20:056), sets the requirements for registration as an ARNP. Any registered nurse functioning as a nurse practitioner in a Family Planning Clinic must be registered by the Board in accordance with the regulation. The Board of Nursing regulation (201 KAR 20:057) adopts the Ob/Gyn Nurse Practitioner scope of practice as defined by the certifying organization. Each Ob/Gyn Nurse Practitioner in a Family Planning Clinic is expected to practice in the expanded role within his/her own educational and clinical background and within the role and function definitions as described by NAACOG.

A 1975 joint statement by NAACOG and ACOG on nurse practitioner functions recognizes that the physician cannot under all circumstances be physically present. However, it is essential that the ARNP function within the framework of a medically directed service, with readily available medical collaboration. A current medically approved protocol agreed on by the ARNP and a specific physician must be available at each clinic site where the ARNP practices.

The protocol should provide for all situations expected to be encountered, and should limit the activity of the ARNP to only those duties for which he/she is properly prepared. It shall be the responsibility of the agency as well as the nurse to comply with these legalities. It is imperative that each ARNP provide for himself/herself, or have provided for him/her, liability insurance.

Definition of an Ob/Gyn ARNP:

An Ob/Gyn ARNP is a registered nurse who is qualified through education, experience, and certification by a national certifying body, to provide highly competent and comprehensive nursing services in health maintenance, disease prevention, psycho-social and physical assessment, and management for health-illness needs in the primary care of women. This practitioner functions with considerable independence in initiating and managing clinical services within established regimens, but also functions interdependently with other colleagues in the health care system.

GUIDELINES FOR THE UTILIZATION OF THE ADVANCED REGISTERED NURSE PRACTITIONER (OTHER THAN OB/GYN) IN A FAMILY PLANNING CLINIC

Legal Aspects:

For an Advanced Registered Nurse Practitioner to function in a Family Planning Clinic, he/she must be educationally and clinically prepared to provide family planning and gynecological care. Advanced Registered Nurse Practitioners who have been prepared in specialities other than Ob/Gyn must practice only within the limitations of their specialty designation under a clearly defined medical protocol agreed on by the ARNP and the supervising physician. The protocol must be available at the clinic site. The regulation defining the registration process (201 KAR 20:056) Section 10 (9) limits the nurse practitioner's practice to the specialty to which he/she has been designated and the regulation 201 KAR-20:057 adopts the nurse practitioner scopes of practice defined by the certifying organizations, such as ANA, NAPNAP.

The Family Nurse Practitioner and the Pediatric Nurse Practitioner or Associate may have had a preparation component in women's/adolescent health care. It is imperative that the ARNP designated as a Family Nurse Practitioner or Pediatric Nurse Practitioner function in a Family Planning Clinic only within her educational and clinical preparation. Such ARNP and his/her supervising physician will be responsible for clearly defining the expected role in a Family Planning Clinic only within these parameters. It is essential that each Advanced Registered Nurse Practitioner provide for himself/herself or have provided for him/her, liability insurance for the expanded role.

Policy and Guidelines on Utilization of ARNPs in Family Planning Clinics

The following guidelines have been developed for the use of community health agencies to effectively utilize the ARNP in providing family planning services. Those agencies receiving Federal monies for the implementation of Family Planning Programs are expected to follow these guidelines.

Prior to providing services within clinics Federally funded for family planning and annually by June 1 thereafter, each Advanced Registered Nurse Practitioner must submit to the Division for Maternal and Child Health Services, Family Planning Program, a copy of his/her current Kentucky registration as an ARNP. His/her specialty designation (Family Nurse Practitioner, Pediatric Nurse Practitioner, etc.) must also be identified.

GUIDELINES FOR THE UTILIZATION OF THE ADVANCED REGISTERED NURSE PRACTITIONER (OTHER THAN OB/GYN IN A FAMILY PLANNING CLINIC (Cont.)

A copy of the medical protocol agreed on by the ARNP and collaborating physician must be submitted to the Division for Maternal and Child Health Services, Family Planning Program. Thereafter, only changes in the protocol must be submitted. The protocol must be comprehensive in nature and be applicable to all normal situations which the Advanced Registered Nurse Practitioner may encounter in the Family Planning Clinic. Specific instructions as to oral contraceptive recommended in each situation are to be outlined. Management of minor gynecological problems must be outlined and be specific for the problem.

The medical protocol must be reviewed and updated at least annually by the ARNP and the physician who authorizes him/her to practice in the expanded role.

Each medical record indicating ARNP services reflecting the expanded role, must be reviewed and co-signed by the collaborating physician.

Physician emergency consultation must be readily available for the ARNP providing services in Family Planning Clinics.

REGISTRATION NOTIFICATION

FOR

ADVANCED REGISTERED NURSE PRACTITIONER-NURSE MIDWIFE

THIS IS TO CERTIFY THAT _____ (ARNP-CNM) HAS BEEN CERTIFIED BY _____ AND THE KENTUCKY BOARD OF NURSING
(professional organization)
TO PRACTICE IN THE EXPANDED ROLE OF AN ADVANCED REGISTERED NURSE PRACTITIONER-NURSE MIDWIFE.

THE SERVICES PROVIDED BY _____ (ARNP-CNM) WILL BE IN ACCORDANCE WITH THE POLICIES AND PROCEDURES SET FORTH IN THE KENTUCKY MEDICAL ASSISTANCE NURSE MIDWIFE SERVICES MANUAL.

PHYSICIAN _____
(signature)

ARNP-CNM _____
(signature)

_____
KY. Registered Nurse License Number

_____
ARNP-CNM Certification Number

_____
Date

MEDICAL PROTOCOL ON FILE?
YES____ NO_____

DO YOU HAVE A VALID PERMIT TO PRACTICE MIDWIFERY IN THE STATE OF KENTUCKY?

YES____ NO____

CERTIFICATE NUMBER_____

MAP-347
(6/83)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
STATEMENT OF AUTHORIZATION
(Please Print All Requested Information)

I hereby declare that I, _____ (Licensed Professional),

have entered into a contractual agreement with _____ (Facility Name)

_____ (City, State, Zip)

to provide professional services. I authorize payment to _____ (Facility Name)

_____, from the Kentucky Medical Assistance Program for covered services rendered by me and specified by the criteria of our contract. I understand that I, personally, cannot bill the Kentucky Medical Assistance Program for any service that is reimbursed to _____ (Facility Name) as part of our contractual agreement.

_____ Signature of Professional

_____ Date Signed

_____ License and/or Certification Number

_____ Specialty

_____ Date Contract Effective

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: FAMILY PLANNING SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSON R	3834042135	9883324-552-580	111783-111783	50.00	2.00	0.00	48.00	365
01 PS 6	PROC 01234	QTY 1		111783-111783	30.00	0.00		30.00	61
02 PS 6	PROC 12345	QTY 1		111783-111783	20.00	2.00		18.00	365

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 50.00 TOTAL PAID: 48.00

APPENDIX VIII-A

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: FAMILY PLANNING SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
023104	JONES R	4321712345	9838348-552-010	111783-111783	30.00	254
01 PS 6	PROCEDURE 11122 QTY 1			111783-111783	30.00	

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 30.00

APPENDIX VIII-B

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: FAMILY PLANNING SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

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

PROVIDER INQUIRY

APPENDIX VIII

EDS FEDERAL

FISCAL AGENT OF KMAP

P.O. BOX 2009

FRANKFORT, KY 40602

Attention: Provider Services

PROVIDER NAME AND ADDRESS

PROVIDER NUMBER:

1. TYPE OF CLAIM (CHECK ONE)

1. ☐ HOSPITAL-INPATIENT	5. ☐ HOME HEALTH	9. ☐ TRANSPORTATION
2. ☐ HOSPITAL-OUTPATIENT	6. ☐ PRIMARY CARE	10. ☐ PHARMACY
3. ☐ LONG TERM CARE	7. ☐ VISION	11. ☐ MEDICARE X-OVER
4. ☐ PHYSICIAN	8. ☐ DENTAL	12. ☐ OTHER _____

2. RECIPIENT NAME (LAST, FIRST, MI.)	3. MEDICAL ASSISTANCE NUMBER		
4. INTERNAL CONTROL NUMBER (ICN)	5. CLAIM SERVICE DATE	6. RA DATE — —	7. YOUR ACCOUNT NUMBER

8. PROVIDER'S MESSAGE

SIGNATURE DATE

9. MEDICAID RESPONSE

APPENDIX IX

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

ADJUSTMENT REQUEST FORM

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

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

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

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

12. Signature 13. Date

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

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

APPENDIX X

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, Ky. 40602

Please remit **both** copies of the Inquiry Form to EDS.

1. Provider Number	3. Recipient Name (first, last)
2. Provider Name and Address	4. Medical Assistance Number
	5. Billed Amount / 6. Claim Service Date
	7. RA Date / 8. Internal Control Number
9. Provider's Message	

10. _____
Signature Date

Dear Provider:

_____ This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim. Please resubmit.

_____ This claim paid on _____ in the amount of _____.

_____ We do not understand the nature of your inquiry. Please clarify.

_____ EDS can find no record of receipt of this claim in the last 12 months.

_____ This claim was paid according to Medicaid guidelines.

_____ This claim was denied on _____ for EOB code _____

_____

_____ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other: _____

_____

_____

_____

_____

_____
EDS Date