Commonwealth of Kentucky
KY Medicaid

KYHealthNet Institutional User Manual

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1 Introduction

1.1 What is MEUPS?

MEUPS is an acronym for the Medicaid Enterprise User Provisioning System. It is a single sign-on system that allows users to access multiple applications via a single user name and password. What that means to Kentucky Medicaid Providers is that you can manage your own account, as well as any agent account which you have granted access. You will not see the word *MEUPS* on your screen, but you may hear someone refer to your MEUPS account. It is the same thing as your KYHealth Choices account.

1.2 How Do I Use this System?

When you log in, you will see the KYHealth Choices Home Page and any applications available to you, including Account Management, Authorization Request, KYHealthNet and EMAX on your menu.

Link	Functions for All Users	Functions for Provider Admin Only	Functions for Billing Agents Only
Account Management	Allows you to manage your personal information, change your security question / answer, and reset your password.	Allows you to view agents with access to your account and add an agent to your account.	None
KYHealthNet	Allows user to submit claims, PA requests, check eligibility, etc.	Functions are limited to those that are applicable to the Provider type.	Functions are limited to those authorized by the Provider Administrators.
EMAX	None	Functions are limited to those that are applicable to the Provider type.	Functions are limited to those authorized by the Provider Administrators.

1.3 What is a Provider Administrator?

A Provider Administrator has control of a Provider's account and can grant access to Billing Agents. A Personal Identification Number (PIN) is required to set up a Provider Administrator account, and only one Provider Administrator account can exist for each Kentucky Medicaid provider number.

1.4 What is a Billing Agent?

A Billing Agent is an accountholder who works on behalf of a Provider but is not the Provider Administrator. In other words, the Billing Agent may submit claims on behalf of the Provider, but only as long as the Provider Administrator has granted access to the Billing Agent. A single Billing Agent may work on behalf of multiple providers. An individual may obtain a Billing Agent account to access claims submission, eligibility, etc. by contacting their Provider Administrator who can create their account and grant proper access.

1.5 What is a PIN Number?

Each Kentucky Medicaid Provider has been issued a Personal Identification Number (PIN) which can be used to set up an account. This PIN is the key that "unlocks" the account initially. Instructions for obtaining the PIN are in the next section of this document.

1.5.1 Creating a New Provider User Account for KYHealthNet

The user creating the KYHealthNet account should be the office manager or someone deemed responsible for accessing provider information. A PIN number is required to create a user account. The Electronic Data Interchange (EDI) Helpdesk will assign a PIN number to each KY Medicaid provider ID.

1.5.2 How to Obtain a PIN Number

1. Go to the KY Medicaid Website, www.kymmis.com.
2. Click **Electronic Claims**.
3. Click **EDI Forms**.
4. Click **PIN Release Form**.
5. Complete the attached PIN Release form and return it to the EDI Helpdesk along with a copy of a valid driver's license via e-mail or fax. Include your phone number and e-mail address and someone will contact you with your PIN and website information.
    a. Fax your PIN Release form to: 502-209-3200
    b. E-mail your form to: KY_EDI_Helpdesk@dxc.com

The DXC EDI department will respond within 2 business days via email.

The PIN release email example is below:

From: Jane.doe@dxc.com
Sent: Monday, August 9, 2019 10:30 AM
To: Daisy.Duck@anywhere.com
Subject: KY Medicaid PIN release request

To create a KYHealthNet account, use the following information:

Provider ID = XXXXXXXXXX

PIN # = XXXXXXXXX

To create a KYHealthNet account, access https://public.kymmis.com/pinletter/

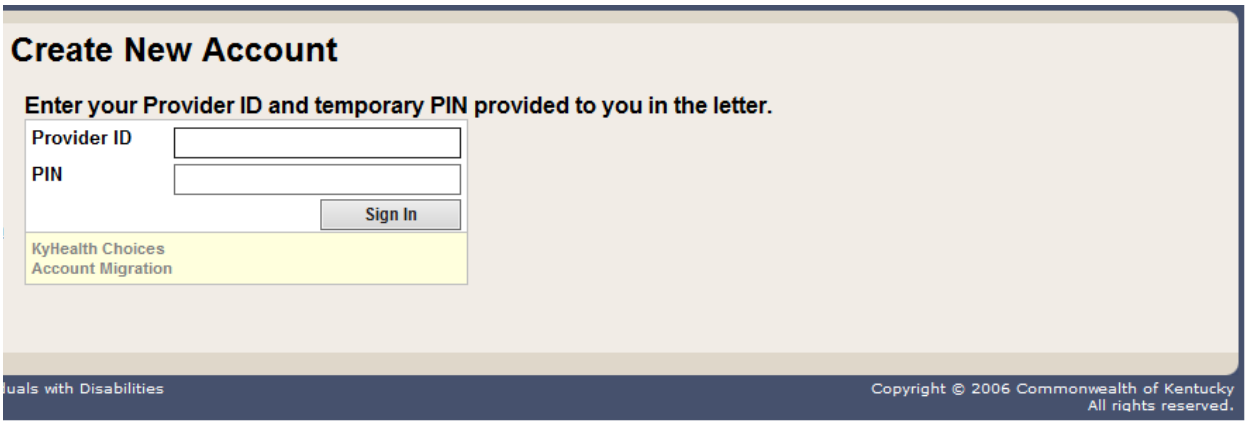
To access the user account: http://home.kymmis.com/

The password expires every 30 days. A reminder is sent on the 20th day to update the password. To change your password, click Account Management, Change my password.

In the future you can do the following: If the account user password is expired click the 'Forgot my password' button on the sign in page under password to complete a password update. This function only works if a security question is linked to the account. If you have questions, contact the EDI Helpdesk at 800.205.4696 or KY_EDI_Helpdesk@dxc.com.

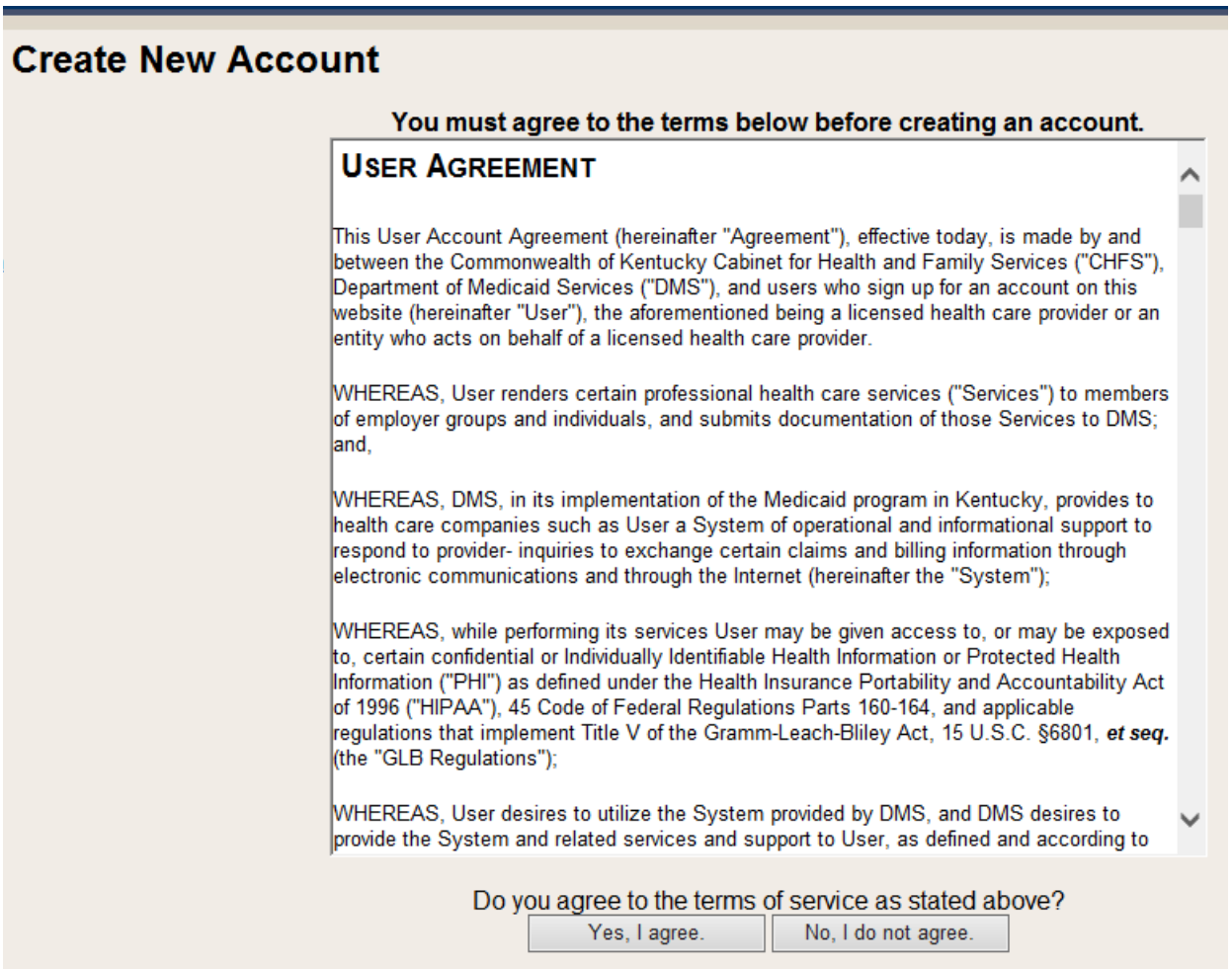
1.5.3 Using the PIN to Create a New Account

1. Enter the provider ID (KY Medicaid provider ID or Group id).
2. Enter the PIN number assigned.

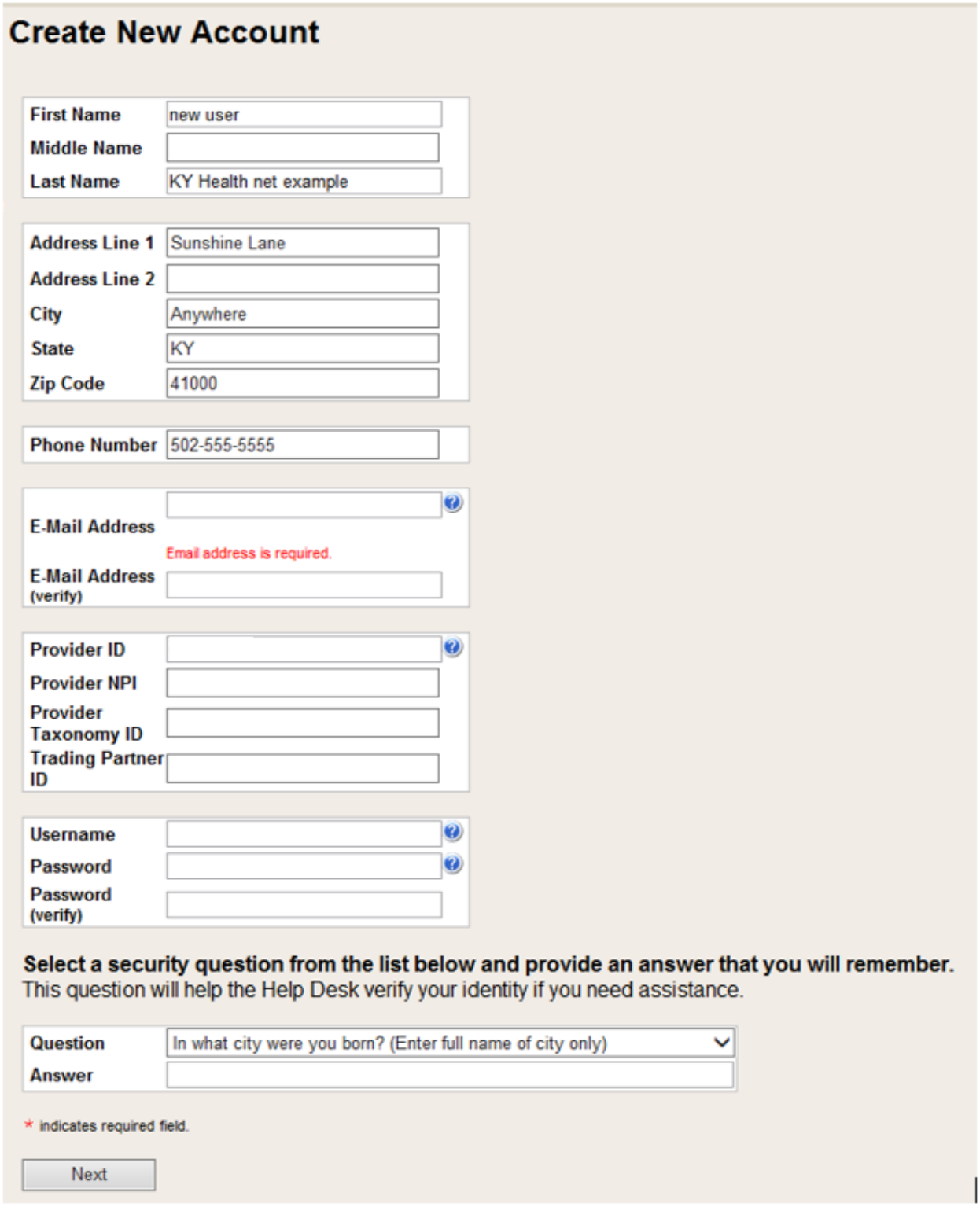


A **User Agreement to Terms of Service** window will display.

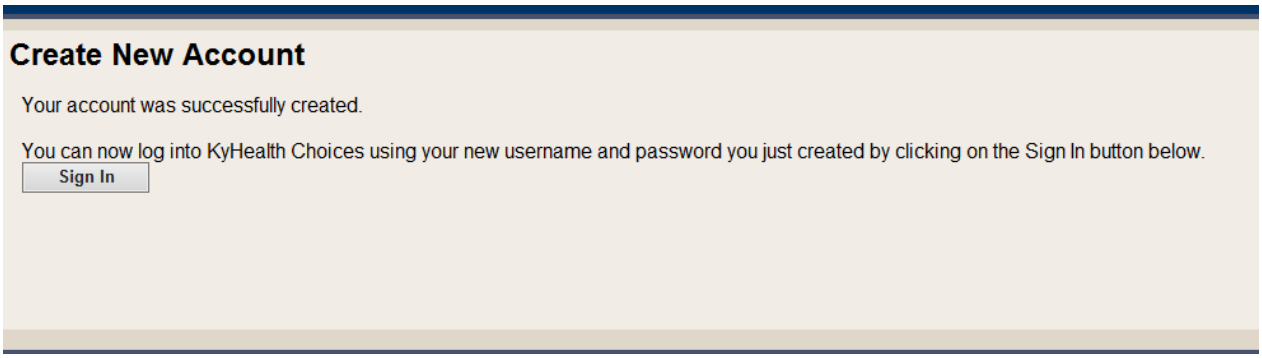
3. Click the **Yes, I agree** or **No, I do not agree** button.



4. Enter the data on the **Create New Account** form.



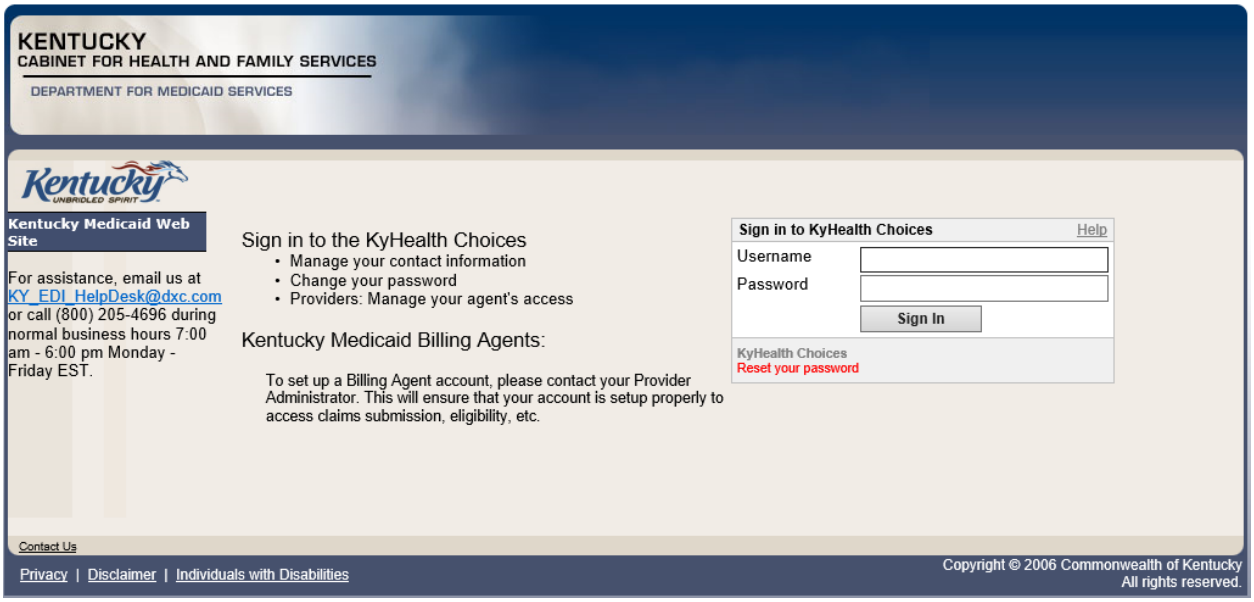
The **Your account was successfully created** window will display.



2 Signing into KYHealth Choices

2.1 Sign into KYHealth Choices

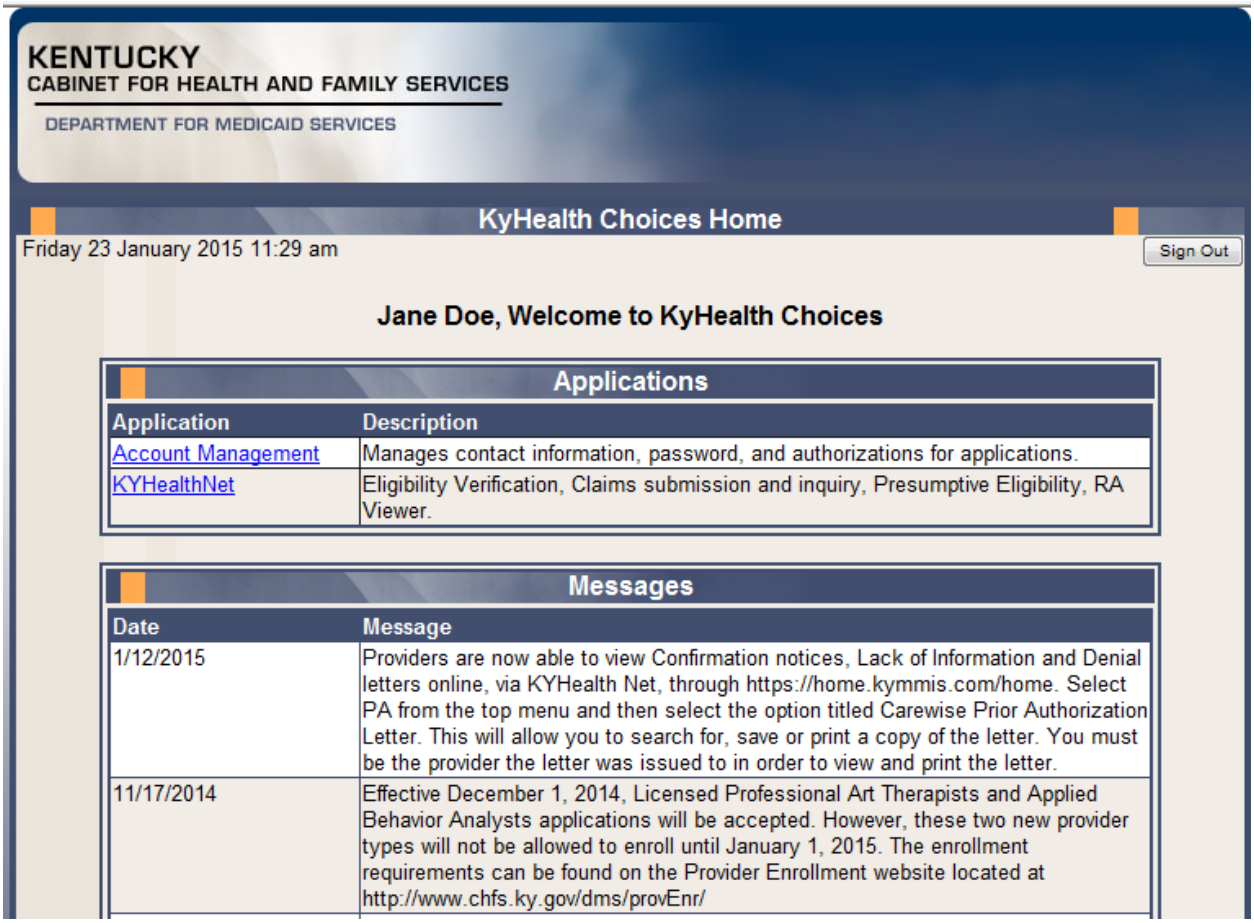
1. Access https://home.kymmis.com
2. Enter the username and password.



2.2 Accessing User Applications

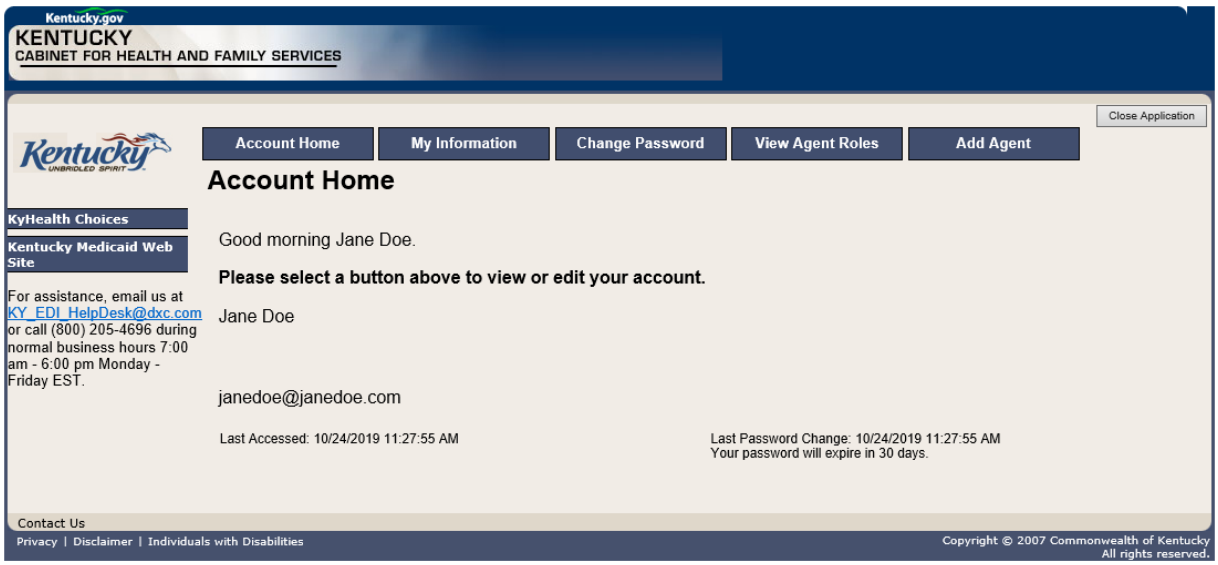
The Administrator to the provider account can view or add agents. An agent has limited access to change passwords or update security questions.

1. Click **Account Management** under **Application**.

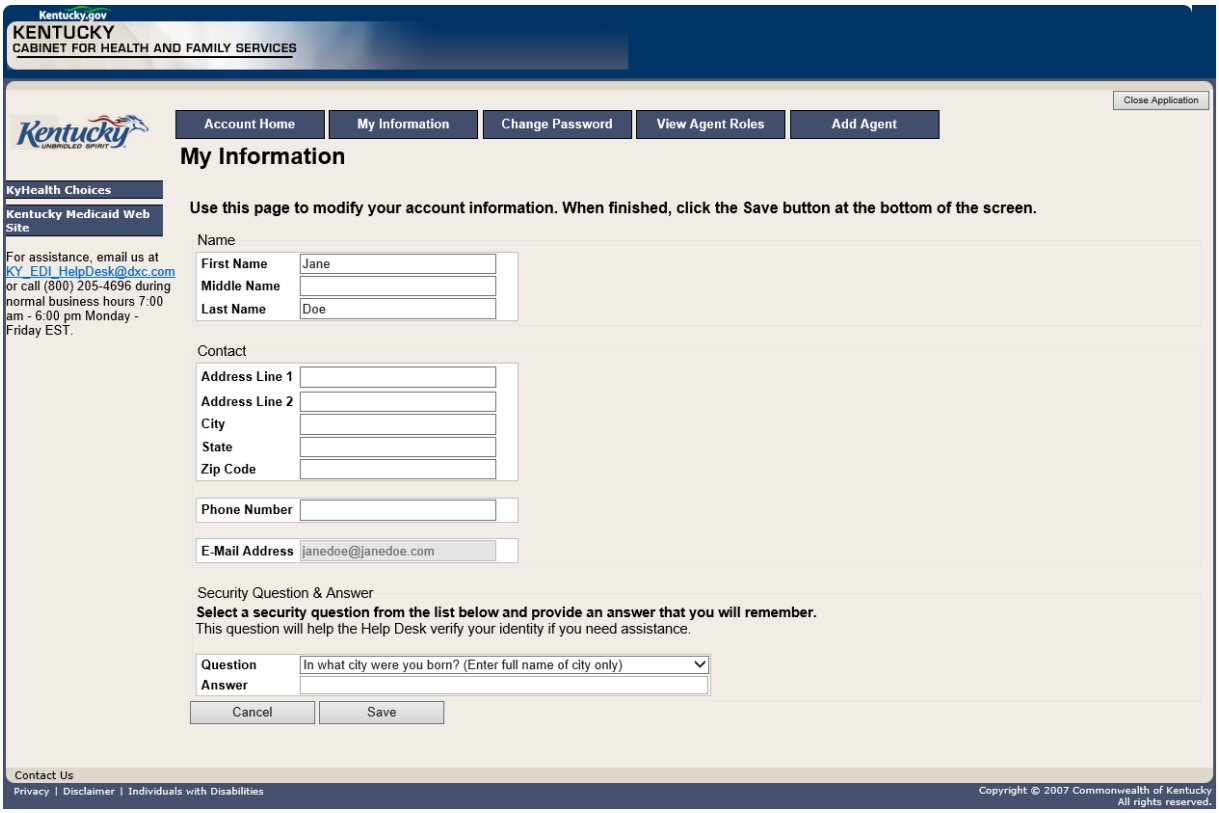


The **Account Management** screen displays.

The functionality available is:	
Account Home	Click and return to the home page (Admin and Agent).
My Information	Allows the user to update the address, phone number, and security question (Admin and Agent).
View Agent Roles	Allows the provider administrator to view the roles granted to an agent.
Change Password	Allows the user to change the current password (Admin and Agent).
Add Agent	Allows the provider administrator to add agents.



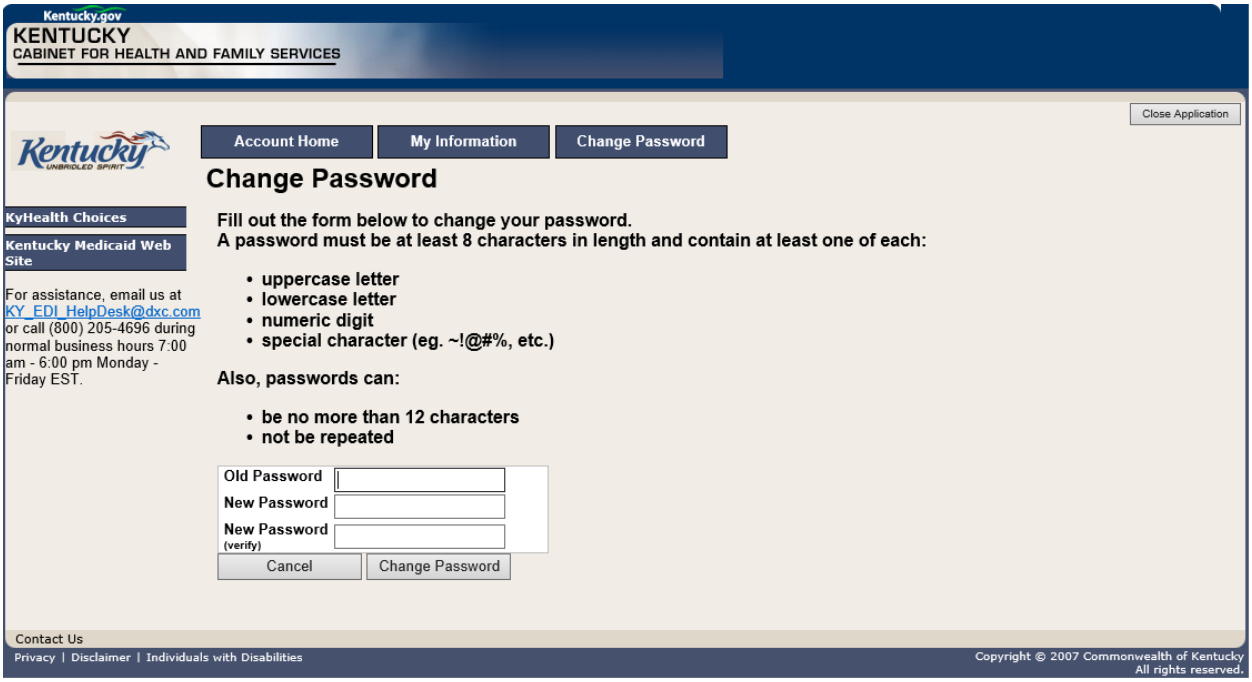
2. Click the **My Information** button and the following screen displays.
3. Scroll down to the **Security Question & Answer** section.
4. Review current security question/answer or select a new security question and enter an answer.
5. Click **Save** to record any changes.



2.2.1 How to Change the Password

The account password expires every 30 days. A pink banner will display on the Home page showing the days remaining to password expiration beginning with 10. The user will receive an email notification from MEUPS prior to the expiration on the 20th day.

1. Click the **Change Password** button.
2. Complete form.
3. Click the **Change Password** button.



2.2.2 Email Examples of Password Reminder and Account Change Notification

From: MEUPS Automated Mailer [mailto:MEUPS_DoNotReply@email.kymmis.com]
Sent: Friday, July 16, 2019 1:30 PM
To: Doe, Jane
Subject: PASSWORD EXPIRATION REMINDER: 10 days left
Sensitivity: Confidential

Kentucky user Jane Doe,

Your Medicaid system account password will expire in 10 days on Monday, July 26, 2010. Please change your password before then to ensure uninterrupted system access.

Please contact the EDI helpdesk at KY_EDI_HelpDesk@dxc.com or call (800) 205-4696 between 7:00 am - 6:00 pm Monday - Friday EST should you have questions regarding this notification.

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MO

From: MEUPS Automated Mailer [mailto:MEUPS_DoNotReply@email.kymmis.com]
Sent: Wednesday, August 18, 2019 2:00 PM
To: Doe, Jane
Subject: ACCOUNT CHANGE NOTIFICATION
Sensitivity: Confidential

Kentucky user Jane Doe,

KYHealth Choices sends you this account change notification for your information. No action on your part is required. The following changes have been made recently against your systems account:

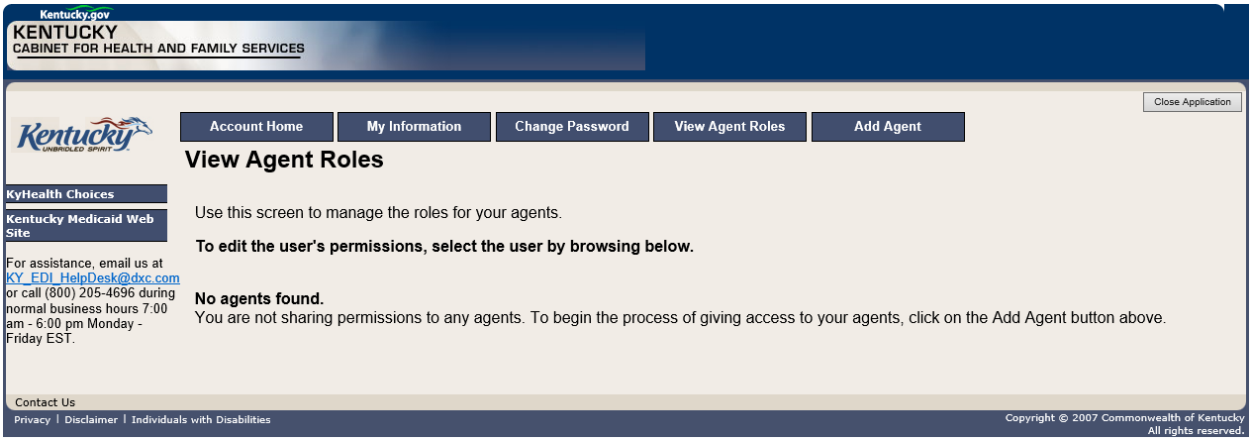
Date of Change	Description
Aug 18 2019 1:30PM	Account access has been reinstated
Aug 18 2019 1:32PM	Password changed

Please contact the EDI helpdesk at KY_EDI_HelpDesk@dxc.com or call (800) 205-4696 between 7:00 am - 6:00 pm Monday - Friday EST if you have questions about any of these changes.

KYHealth Choices

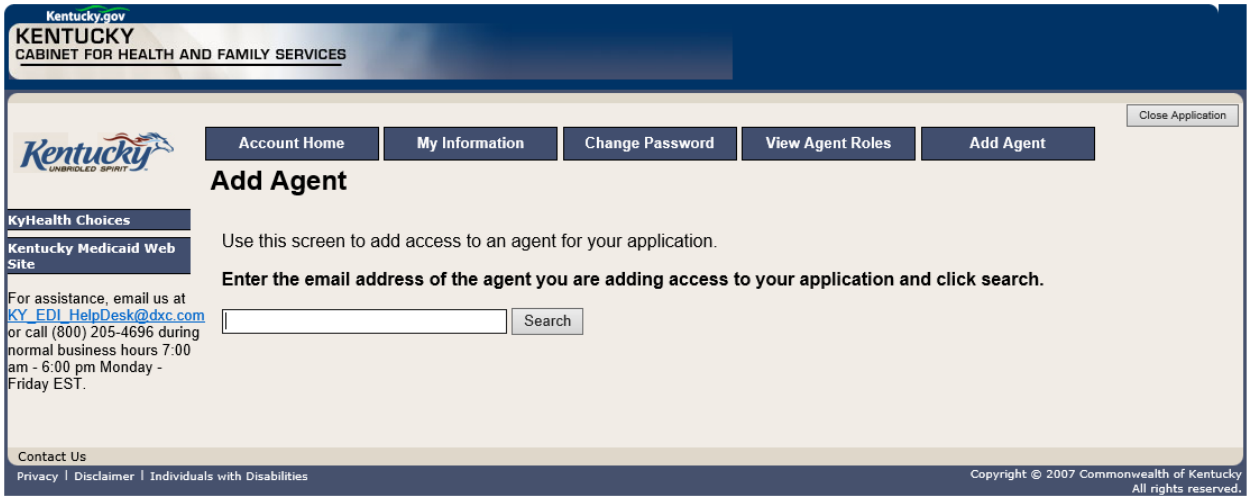
2.3 Viewing Agent Roles

Provider Administrators and Billing Agents have the ability to add agents to an account, giving them access to submit claims, check claim status, check eligibility, or perform other functions on behalf of the provider. Clicking **View Agent Roles** will allow a Provider Administrator or Billing Agent to see the agents associated with an account. If no agents have been added, "No agents found" will appear.



2.4 Add an Agent or New Employee

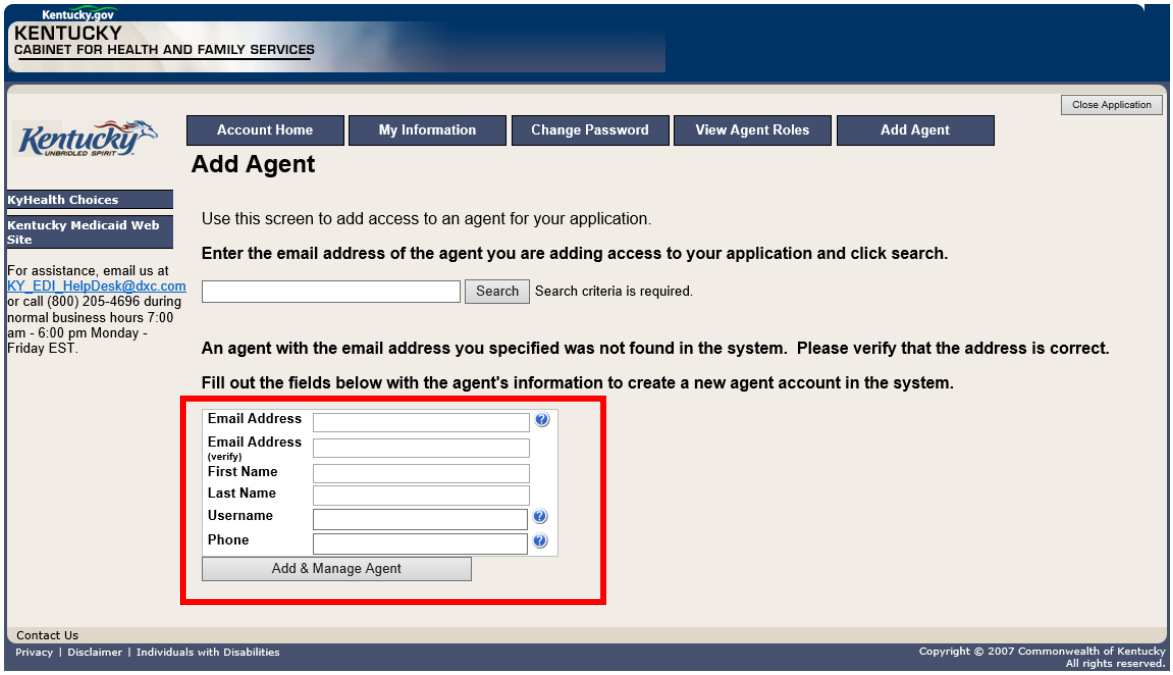
Provider Administrators and Billing Agents have the ability to add agents to an account, giving them access to submit claims, check claim status, check eligibility, or perform other functions on behalf of the provider. Clicking **Add Agen**t allows a Provider Administrator or Billing Agent to add an agent to the account.



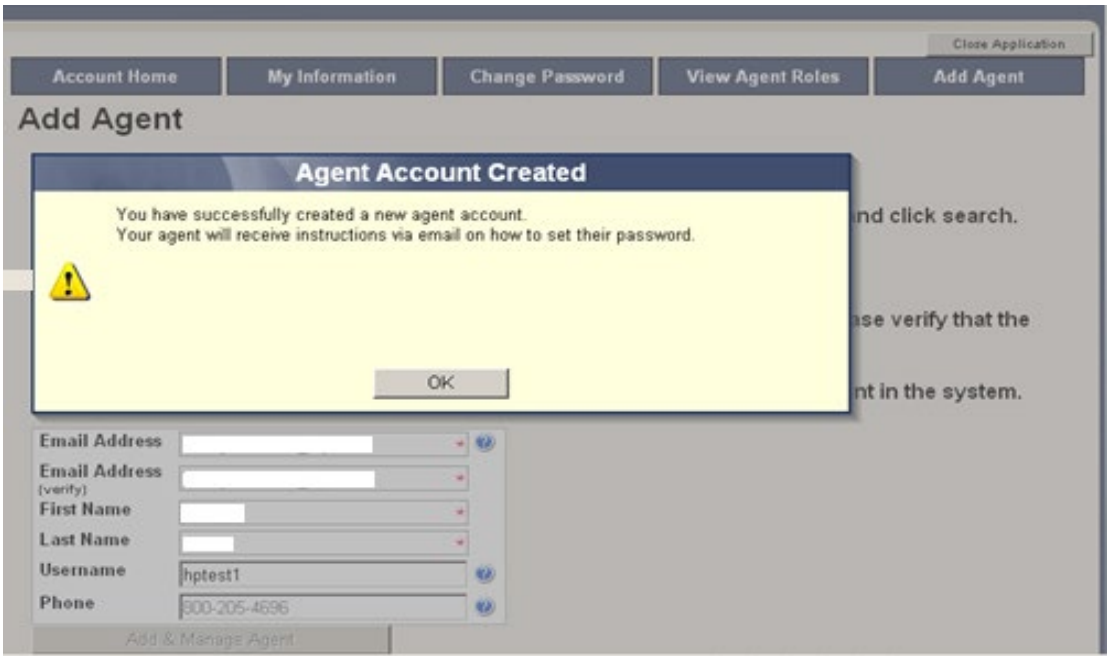
2.4.1 No Email Address Found: Create Username

The Provider Administrator or Billing Agent may search for an existing agent by entering the email address of the agent and clicking **Search**. If no agent is found, the screen below will appear, allowing the user to create an Agent account and associate that agent with the Provider account.

1. Complete the fields boxed in red below.
2. Click the **Add & Manage Agent** button.



3. The **Agent Account Created** window appears.



4. The user will receive an email as shown below.

Automated MEUPS email example:

From: MEUPS Automated Mailer [mailto:MEUPS_DoNotReply@email.kymmis.com]
Sent: Friday, July 16, 2019 1:30 PM
To: Doe, Jane
Subject: PASSWORD SETUP
Sensitivity: Confidential

Kentucky user Jane Doe,

You have been sent this message because you have had a new Medicaid enterprise user account created on your behalf. Your new account username is:

DXCTest1

To establish your password, please visit the following URL and follow the on-screen instructions:

https://public.kymmis.com/testexampleurllink

Please contact the EDI helpdesk at KY_EDI_HelpDesk@dxc.com or call (800) 205-4696 between 7:00 am - 6:00 pm Monday - Friday EST should you have questions regarding this notification.

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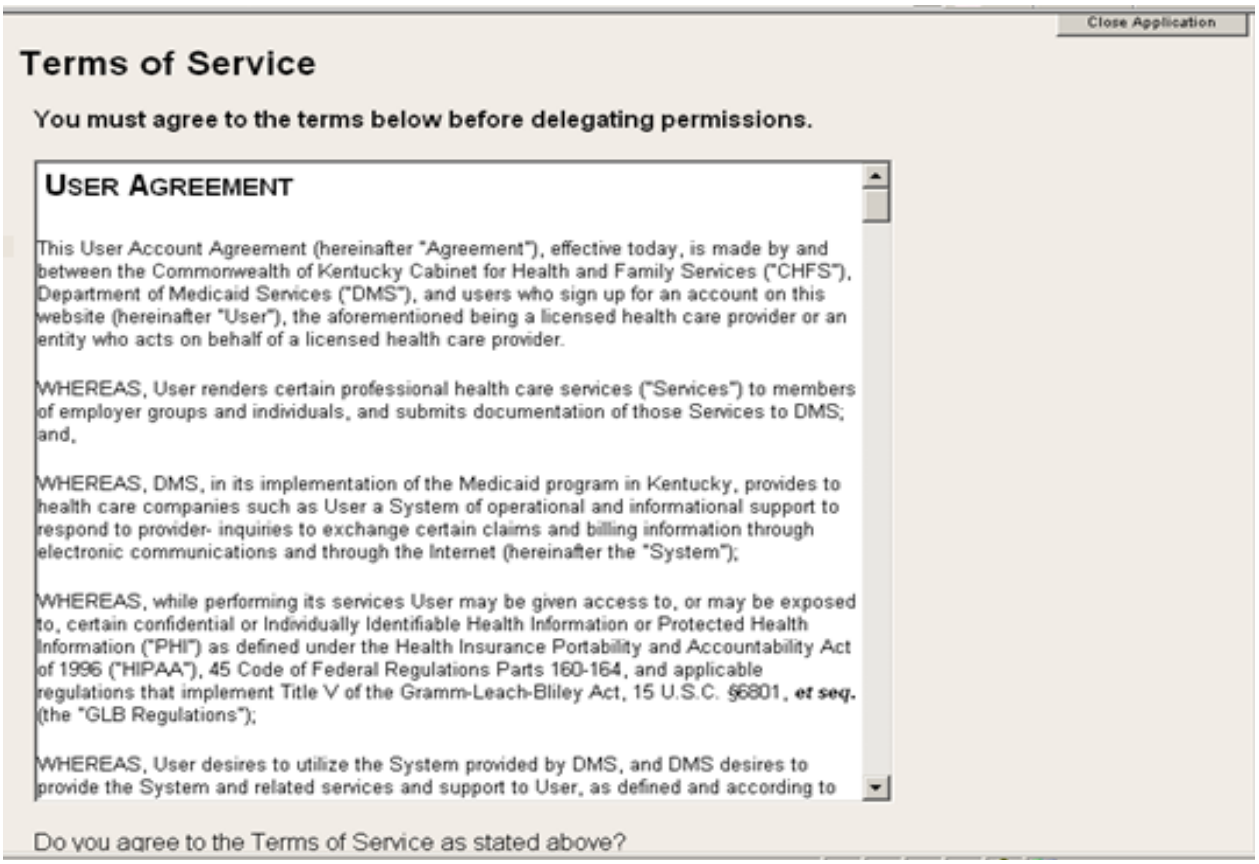
5. When the user clicks the link in the email (example above), the **Terms of Service User Agreement** window appears as shown on the next page.

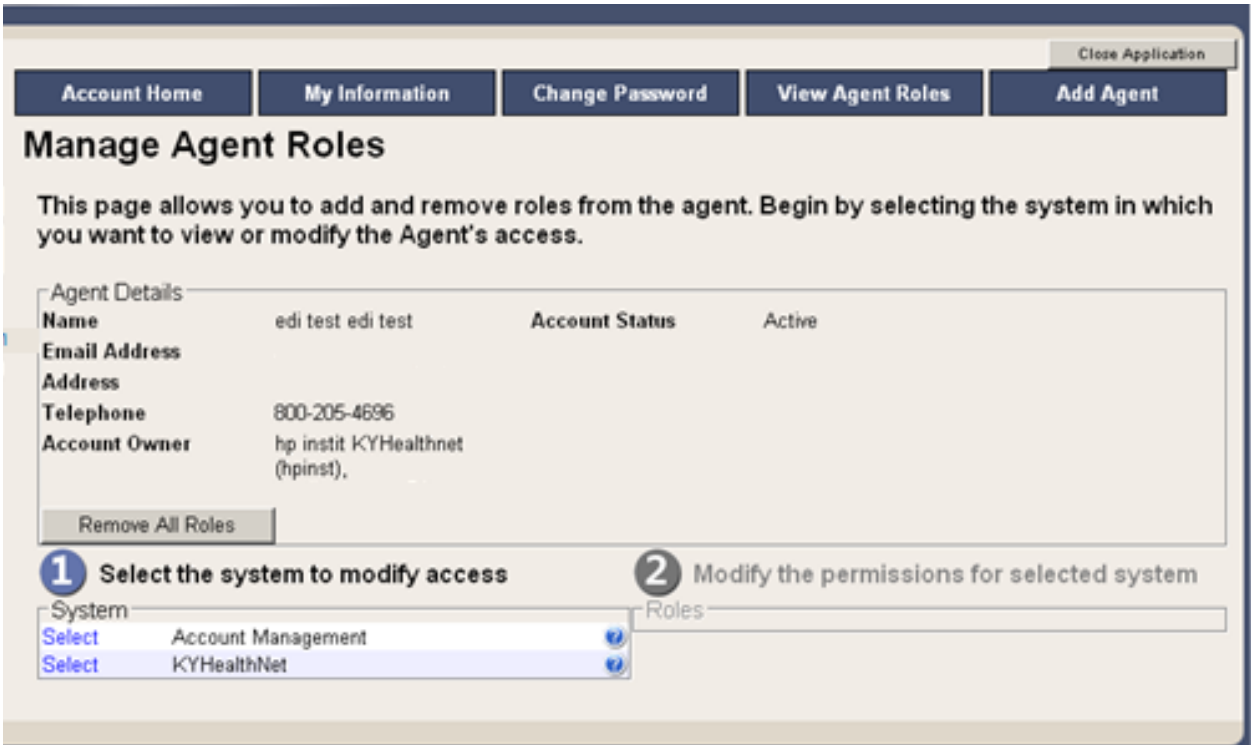
6. The user must click **I agree** in order to proceed.



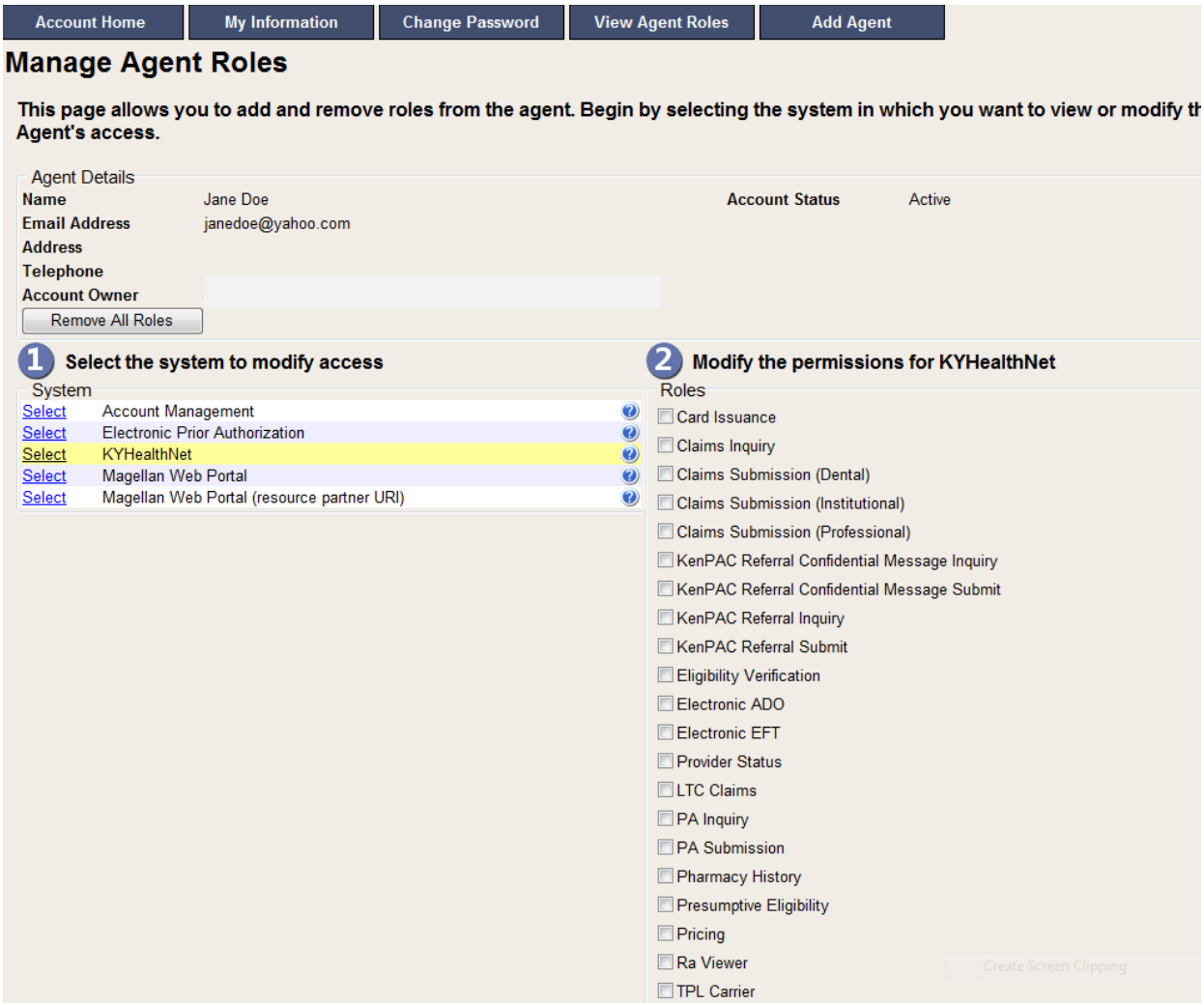
2.5 Manage Agent Roles

After an agent is associated with a Provider account, permissions or "roles" must be granted in order for that agent to act on the Provider's behalf. To add roles for KYHealthNet (claims, eligibility, etc.), follow the instructions below.

1. Click on the **KYHealthNet** link.

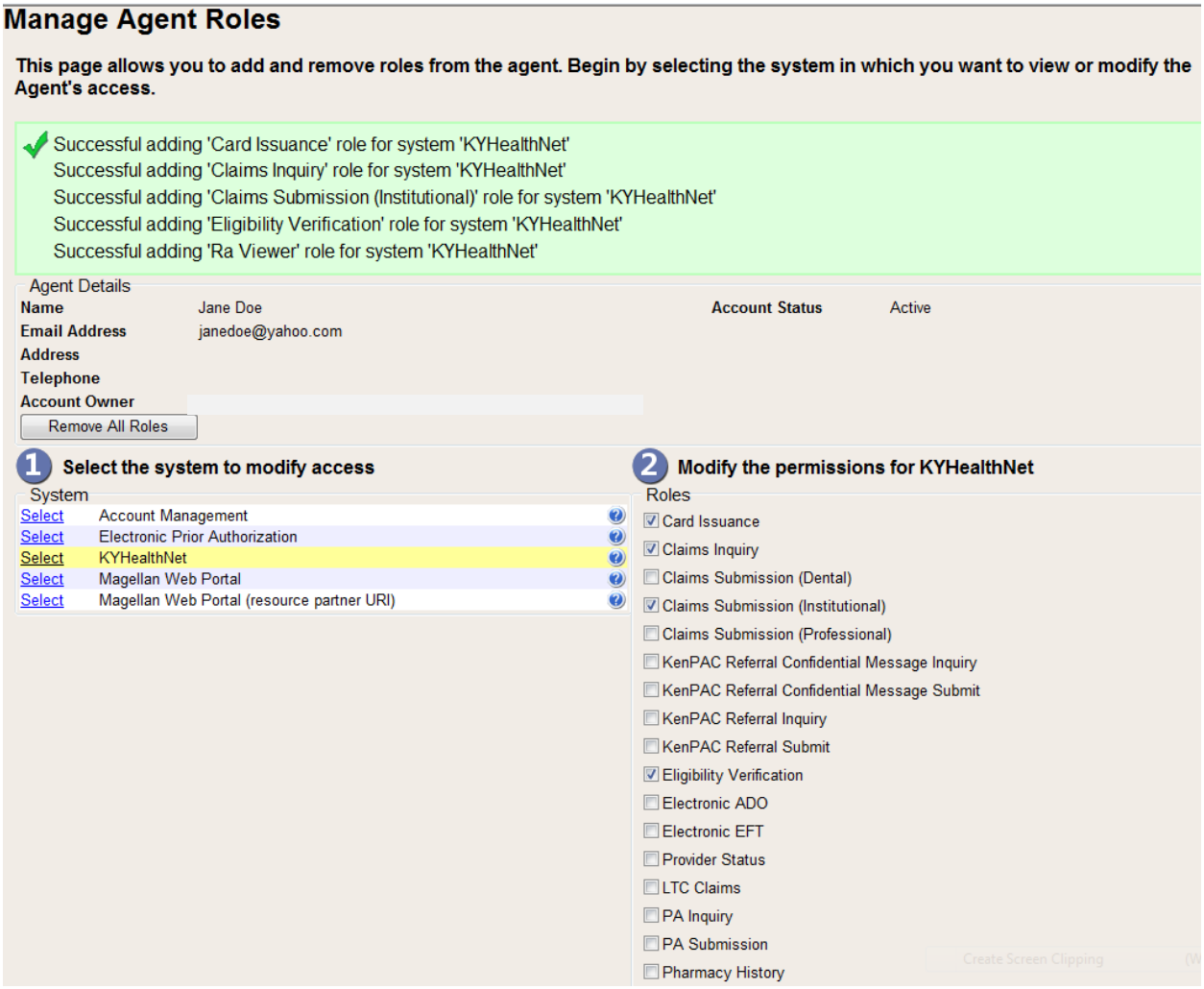


2. Notice that section 2 **Modify the permissions for KYHealthNet** opens.
3. Roles are granted or removed in this section.



4. Check the roles you wish to grant the agent.
5. Click the **Save Changes** button to save the modifications.

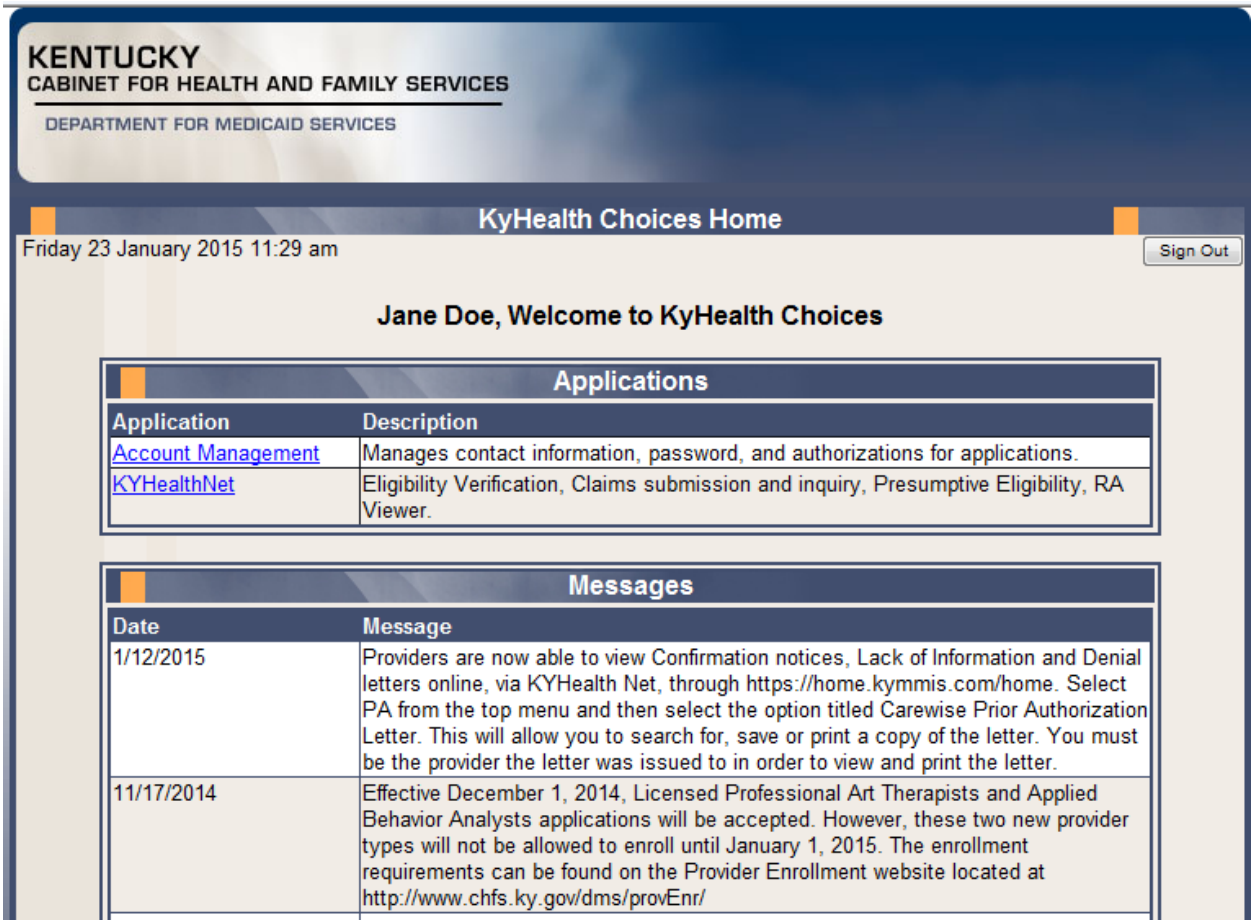
The screen returns **Successful adding role of …**



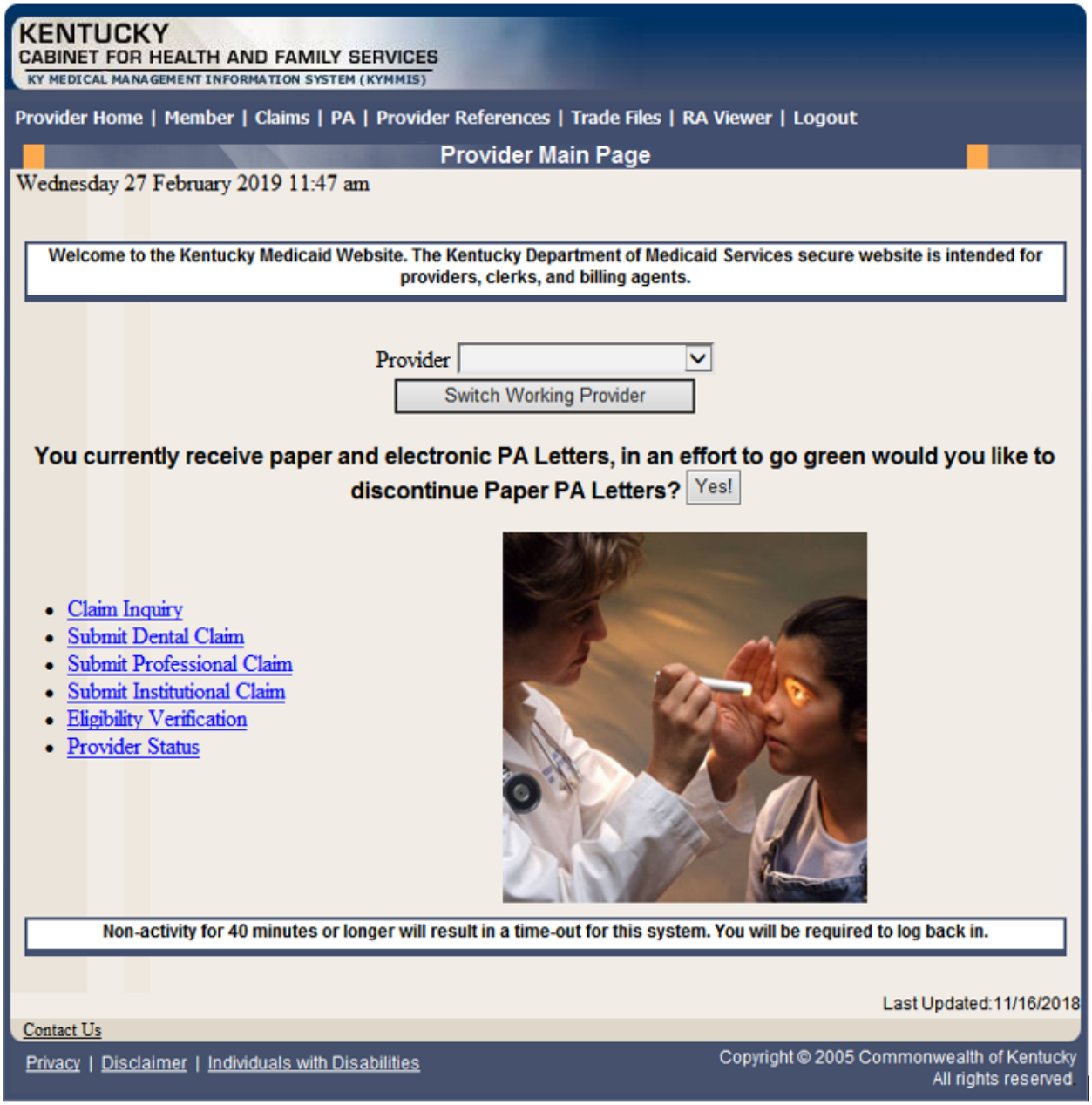
3 Accessing KYHealthNet

KYHealthNet allows users to access Member eligibility and related functions, submit claims, adjust or void claims, check claim status, check Prior Authorization requests, print Prior Authorization letters, view or download remittance advice statements, and access other valuable information.

1. On the **KyHealth Choices Home** page, click the **KYHealthNet** link.



2. Select/verify the Provider's NPI/Taxonomy in the drop-down box.



NOTE: The drop-down only appears if the user is an agent for multiple providers; otherwise, the agent will see only one provider's NPI/taxonomy in the box.

4 Functionality

Provider Administrators have access to all applicable functions on KYHealthNet. Billing Agents and Agents have access to only those functions granted them by the Provider Administrator. A Billing Agent or Agent may only perform the functions granted them by a given Provider Administrator while logged in under that provider's account.

For example, if an agent works on behalf of Dr. Smith and Dr. Jones, but the agent does not have claim submission access for Dr. Jones, the claim submission function will not appear unless the agent has selected Dr. Smith's NPI/Taxonomy from the drop-down when logging in.

KYHealthNet offers the following functions:

Menu Selection	Functions
Member	Check eligibility, benefit issuance, spend down, patient liability, pharmacy history, and MCO member information.
Claims	Check claim status, submit claims, adjust paid claims or void paid claims, and access to view MMIS EOB Codes.
Prior Authorization (PA)	Access PA information, download a PA letter, or lookup a PA number.
Provider References	Access to provider resources on the DMS website.
RA Viewer	View and/or download your Remittance Advice.

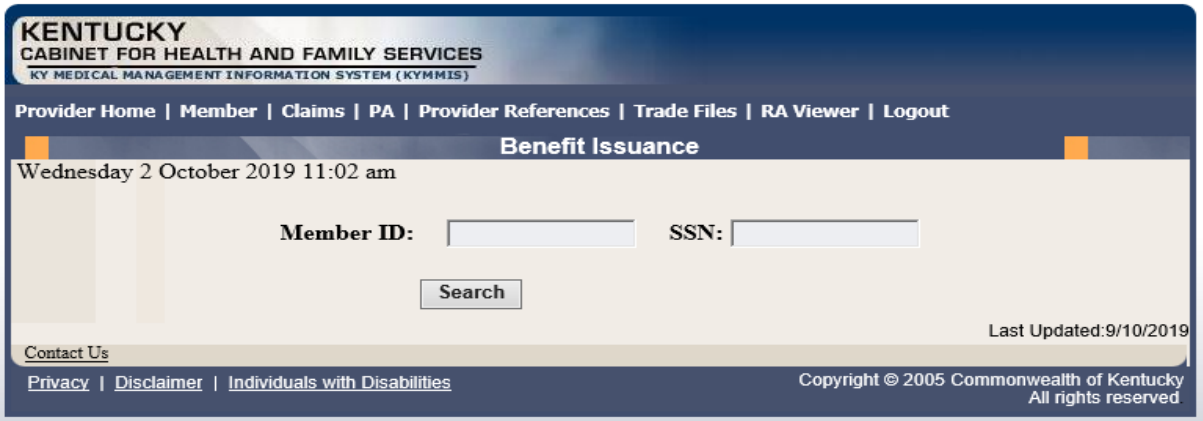
The hyperlinks on the Home page also offer quick access to commonly used functions.

5 Member Information

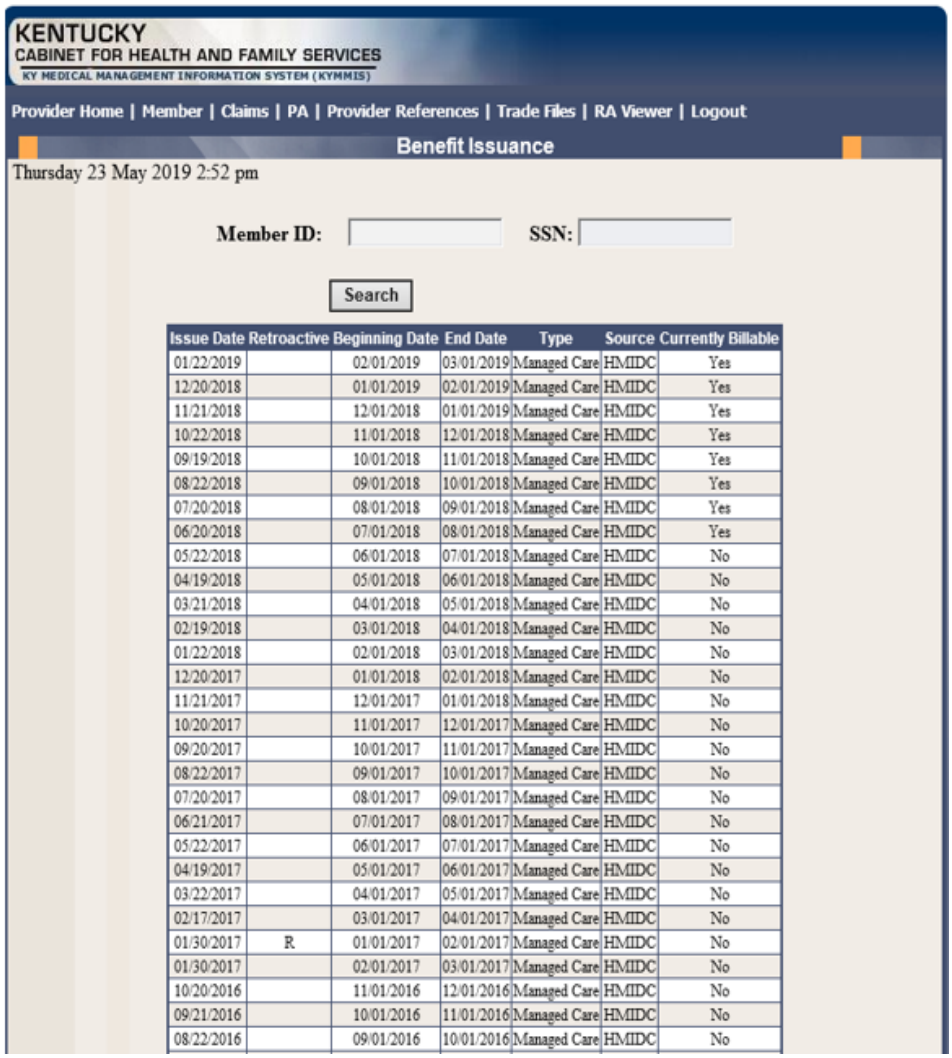
5.1 Member Benefit Issuance

1. Select **Member** from the menu.
2. Choose **Benefit Issuance** from the drop-down.

3. Enter the Member ID or SSN# and click the **Search** button to find the Medicaid benefits issue date.



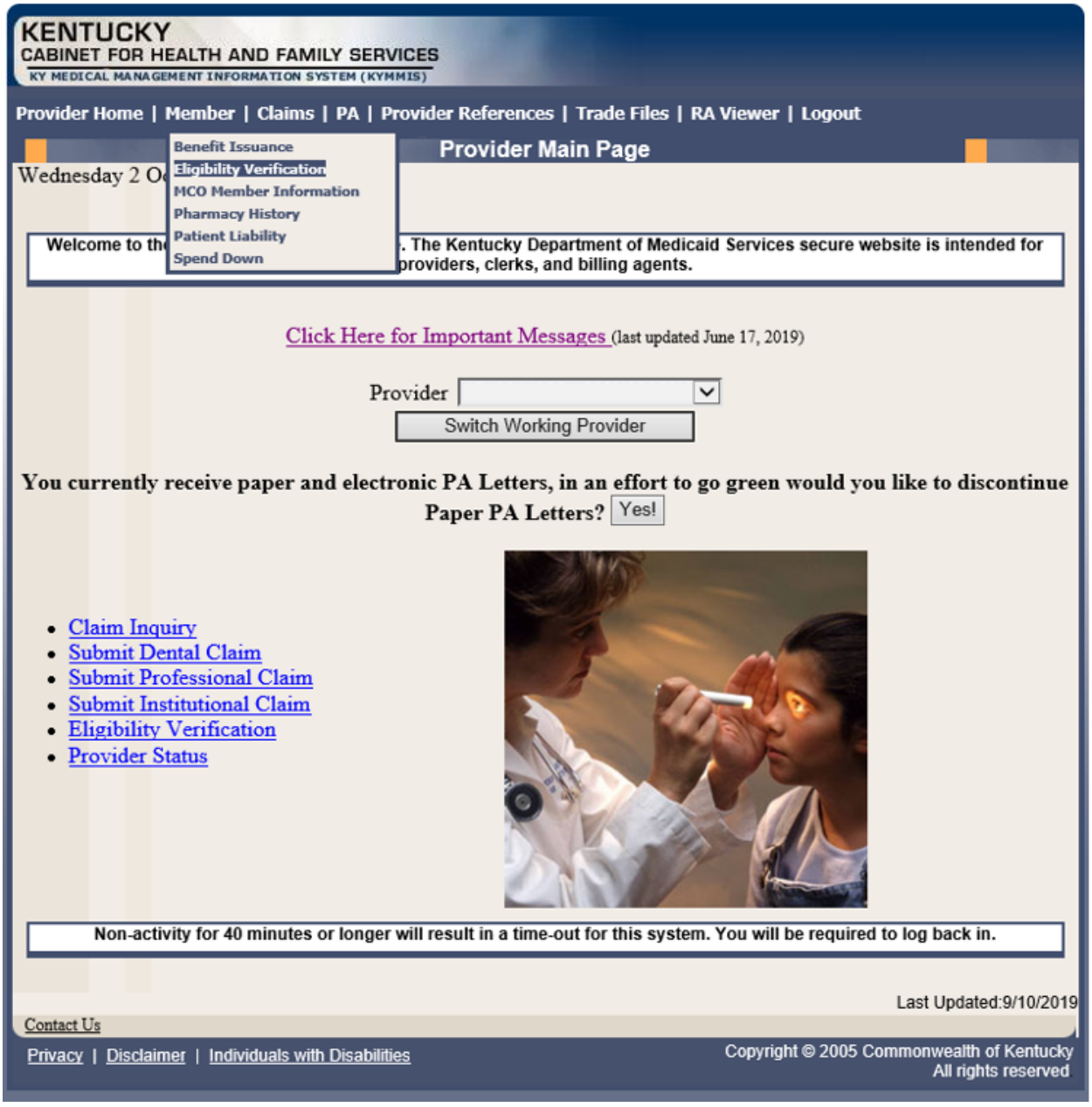
The benefit issuance dates include eligibility begin and end dates along with card type. An **R** in the retroactive column indicates the segment was issued retroactively. Benefit Issuance is no longer current as of Sept 2023. However, historical records are still available.



Issue Date	Retroactive	Beginning Date	End Date	Type	Source	Currently Billable
01/22/2019		02/01/2019	03/01/2019	Managed Care	HMIDC	Yes
12/20/2018		01/01/2019	02/01/2019	Managed Care	HMIDC	Yes
11/21/2018		12/01/2018	01/01/2019	Managed Care	HMIDC	Yes
10/22/2018		11/01/2018	12/01/2018	Managed Care	HMIDC	Yes
09/19/2018		10/01/2018	11/01/2018	Managed Care	HMIDC	Yes
08/22/2018		09/01/2018	10/01/2018	Managed Care	HMIDC	Yes
07/20/2018		08/01/2018	09/01/2018	Managed Care	HMIDC	Yes
06/20/2018		07/01/2018	08/01/2018	Managed Care	HMIDC	Yes
05/22/2018		06/01/2018	07/01/2018	Managed Care	HMIDC	No
04/19/2018		05/01/2018	06/01/2018	Managed Care	HMIDC	No
03/21/2018		04/01/2018	05/01/2018	Managed Care	HMIDC	No
02/19/2018		03/01/2018	04/01/2018	Managed Care	HMIDC	No
01/22/2018		02/01/2018	03/01/2018	Managed Care	HMIDC	No
12/20/2017		01/01/2018	02/01/2018	Managed Care	HMIDC	No
11/21/2017		12/01/2017	01/01/2018	Managed Care	HMIDC	No
10/20/2017		11/01/2017	12/01/2017	Managed Care	HMIDC	No
09/20/2017		10/01/2017	11/01/2017	Managed Care	HMIDC	No
08/22/2017		09/01/2017	10/01/2017	Managed Care	HMIDC	No
07/20/2017		08/01/2017	09/01/2017	Managed Care	HMIDC	No
06/21/2017		07/01/2017	08/01/2017	Managed Care	HMIDC	No
05/22/2017		06/01/2017	07/01/2017	Managed Care	HMIDC	No
04/19/2017		05/01/2017	06/01/2017	Managed Care	HMIDC	No
03/22/2017		04/01/2017	05/01/2017	Managed Care	HMIDC	No
02/17/2017		03/01/2017	04/01/2017	Managed Care	HMIDC	No
01/30/2017	R	01/01/2017	02/01/2017	Managed Care	HMIDC	No
01/30/2017		02/01/2017	03/01/2017	Managed Care	HMIDC	No
10/20/2016		11/01/2016	12/01/2016	Managed Care	HMIDC	No
09/21/2016		10/01/2016	11/01/2016	Managed Care	HMIDC	No
08/22/2016		09/01/2016	10/01/2016	Managed Care	HMIDC	No

5.2 Member Eligibility Verification

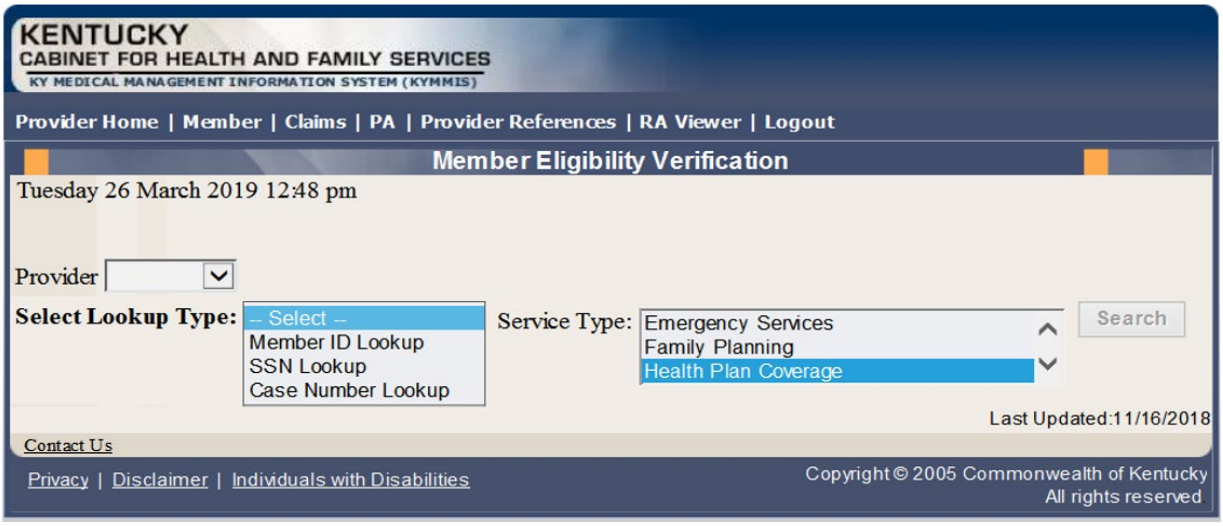
1. Select **Member** from the menu.
2. Choose **Eligibility Verification** from the drop-down.



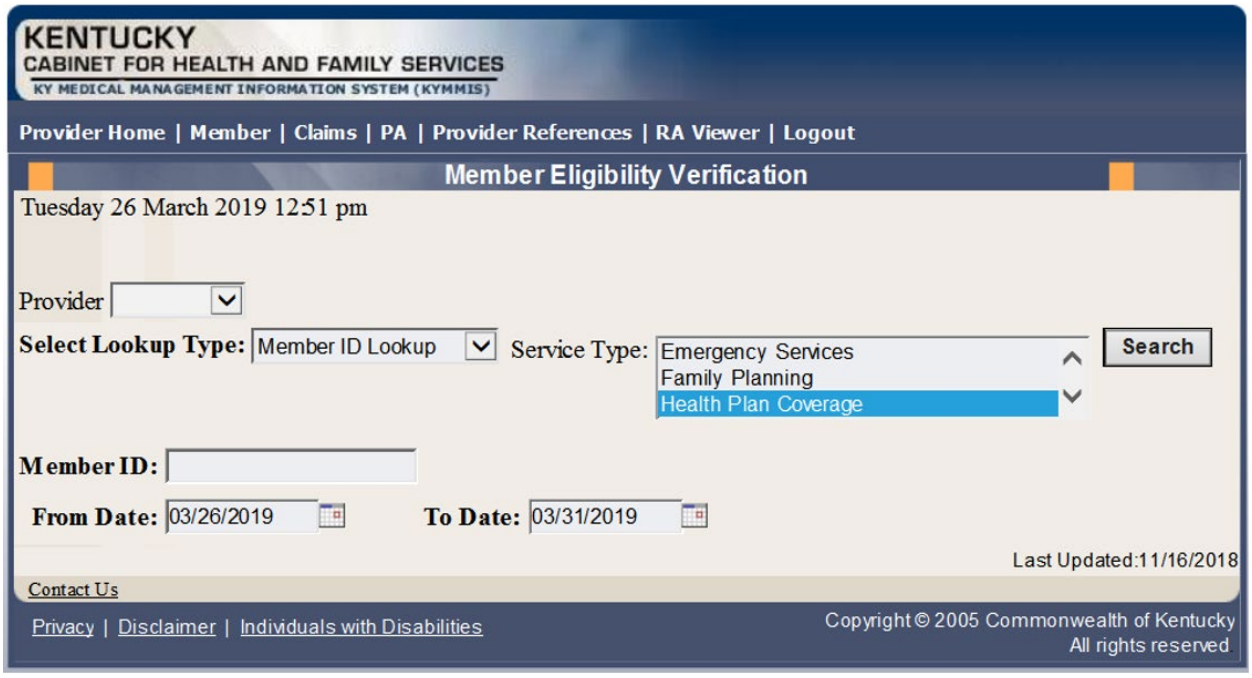
The following screen will appear.

5.2.1 Searching for a Member

1. Click the arrow to the right in the **Select Lookup Type** box and select the criteria to be used in the search.



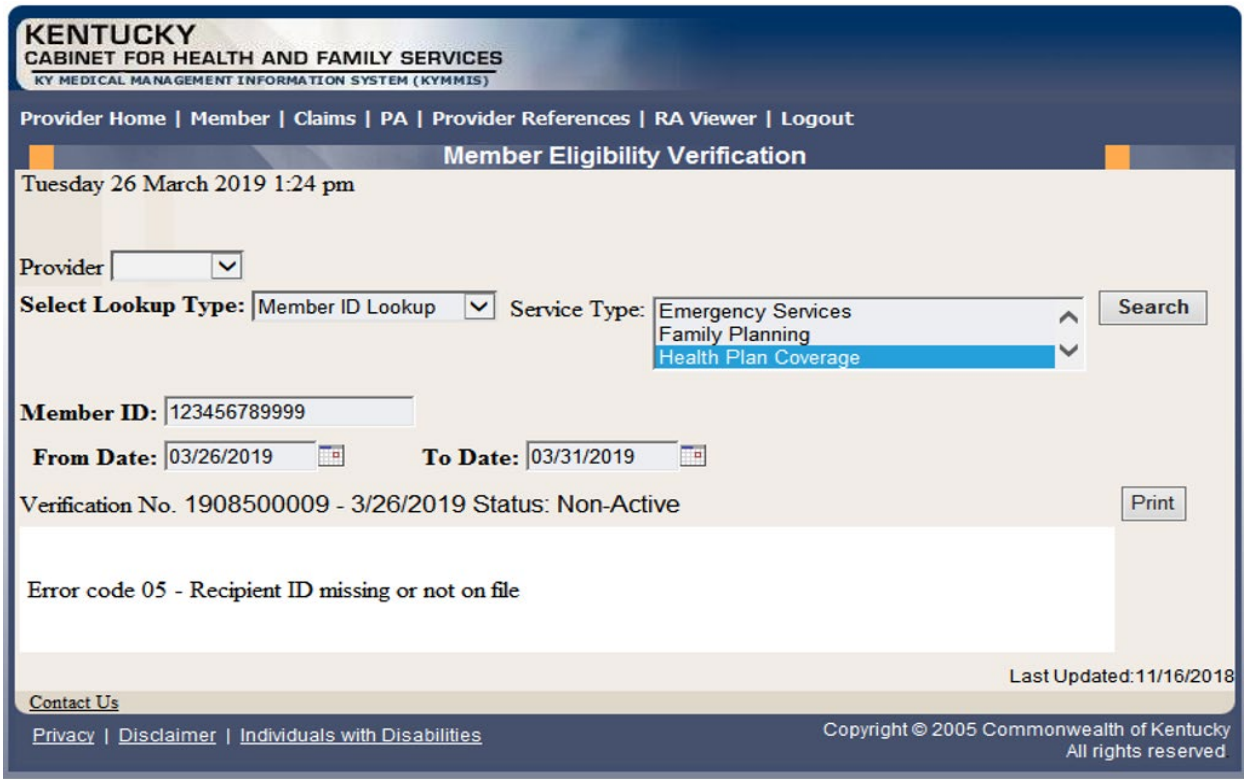
When the search criteria is selected, the screen will expand to include **From Date** and **To Date** fields. The current date will automatically be plugged into the **From Date** field and the last day of the month will be plugged into the **To Date** field. The user may change the dates to the desired dates of service. The system will only allow a look back of 13 months and cannot look at future month's eligibility.



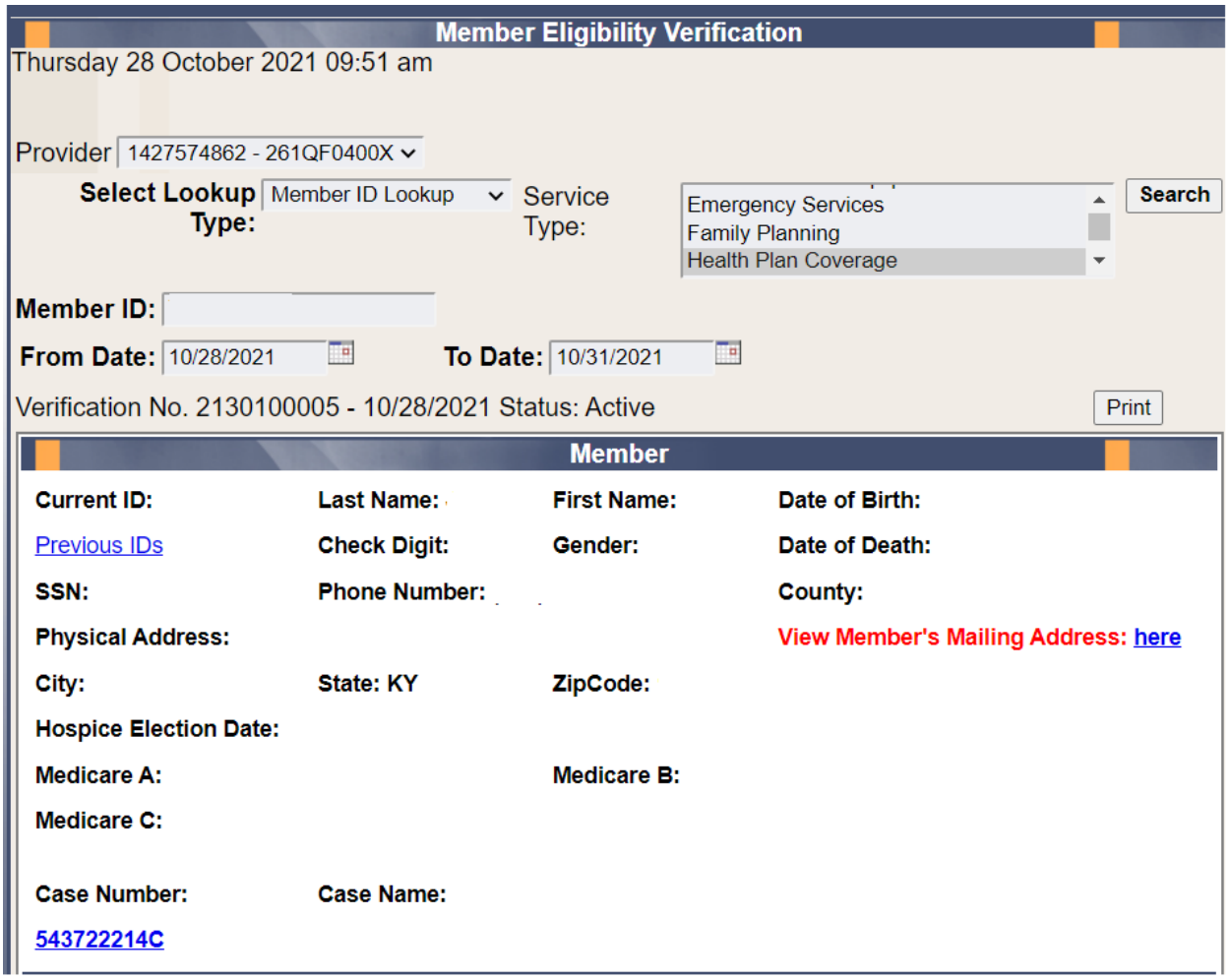
2. Enter the search criteria.
3. Click **Search**.

The **Member Eligibility Verification** page will appear.

- If the member is invalid, does not exist, or has been end dated, an error code will be returned.



Otherwise, this screen will display the most current eligibility information available such as is shown on the screens that follow.


Member Eligibility Verification
Thursday 28 October 2021 09:51 am
Provider 1427574862 - 261QF0400X
Select Lookup Type: Member ID Lookup
Service Type:
Emergency Services
Family Planning
Health Plan Coverage
Search
Member ID:
From Date: 10/28/2021
To Date: 10/31/2021
Verification No. 2130100005 - 10/28/2021 Status: Active
Print
Member
Current ID:
Last Name:
First Name:
Date of Birth:
Previous IDs
Check Digit:
Gender:
Date of Death:
SSN:
Phone Number:
County:
Physical Address:
View Member's Mailing Address: here
City:
State: KY
ZipCode:
Hospice Election Date:
Medicare A:
Medicare B:
Medicare C:
Case Number:
Case Name:
543722214C

963072524 ZAMORANO, LUBA Redetermination Date: Redetermination not required
963072524C GABBERT, COLLETTE S

Member's Authorized Representative

No Authorized Representative on file for current member.

Eligibility

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	From Date	To Date	Last Update
KY Managed Care Organization with Co-Pay	A - Aged indiv 65 and over who rec SSI	ZZ - SSI w/QMB	05/06/2025	05/31/2025	09/23/2022

Copay will be waived for all members, regardless of the member's Benefit Plan. DMS will follow Medicare policy guidelines regarding codes U0001, U0002, G2012 and G2010. The codes will be retroactively effective on February 4, 2020 but will not be billable until after April 1, 2020.

PACE	From Date	To Date
N	05/06/2025	05/31/2025

Copay Indicator	From Date	To Date
Y	05/06/2025	05/31/2025

Note: Above FPL - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.

Please note that the Medicare Savings benefit package, which includes QMB (program code Z), SLMB (program code ZL) and QI1 (Program code ZJ), is not full Medicaid coverage. This benefit package is for members who have Medicare and KY Medicaid pays their Medicare premiums. Of this group, those with Program Code Z or QMB are also eligible for co pays and deductibles.

Service Limitation

Service Limitation 5 Year History

No Service Limitation segment for the dates entered.

Cost Share

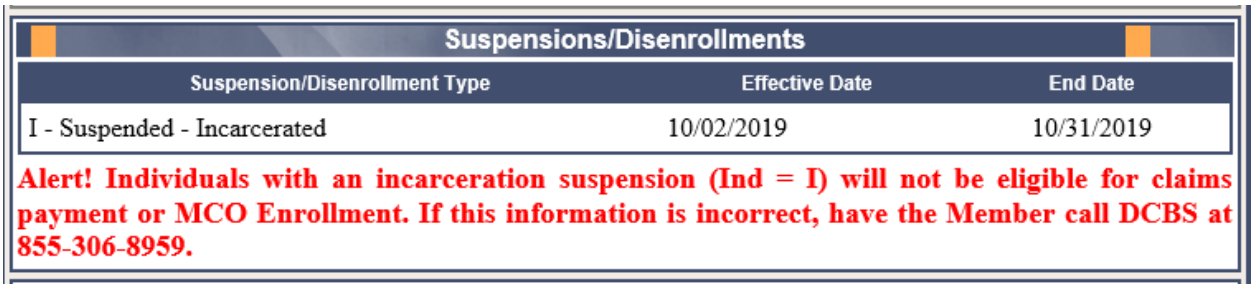
Cost Share 5 Year History

No Cost Share segment for the dates entered.

Each panel on the **Member Eligibility Verification** page above has a link for the last 5 years of history available. Once you click the link, you will be taken to another page to see 5 years' worth of history for the applicable panel.

5.2.2 Member Eligibility Suspension/Disenrollment

This panel will only display if the member is suspended due to incarceration. Otherwise, this panel is not visible. It will appear under the **Member Authorized Rep** panel, above the member's **Eligibility Group** panel and will include a message on where to direct the member.



Suspensions/Disenrollments

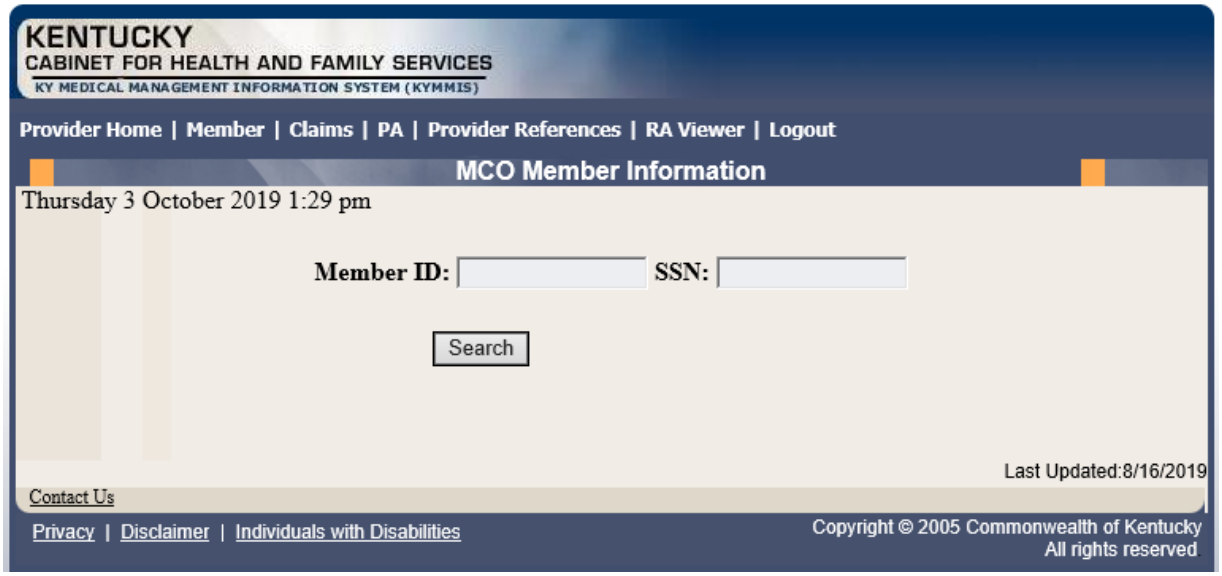
Suspension/Disenrollment Type	Effective Date	End Date
I - Suspended - Incarcerated	10/02/2019	10/31/2019

Alert! Individuals with an incarceration suspension (Ind = I) will not be eligible for claims payment or MCO Enrollment. If this information is incorrect, have the Member call DCBS at 855-306-8959.

5.3 MCO Member Information

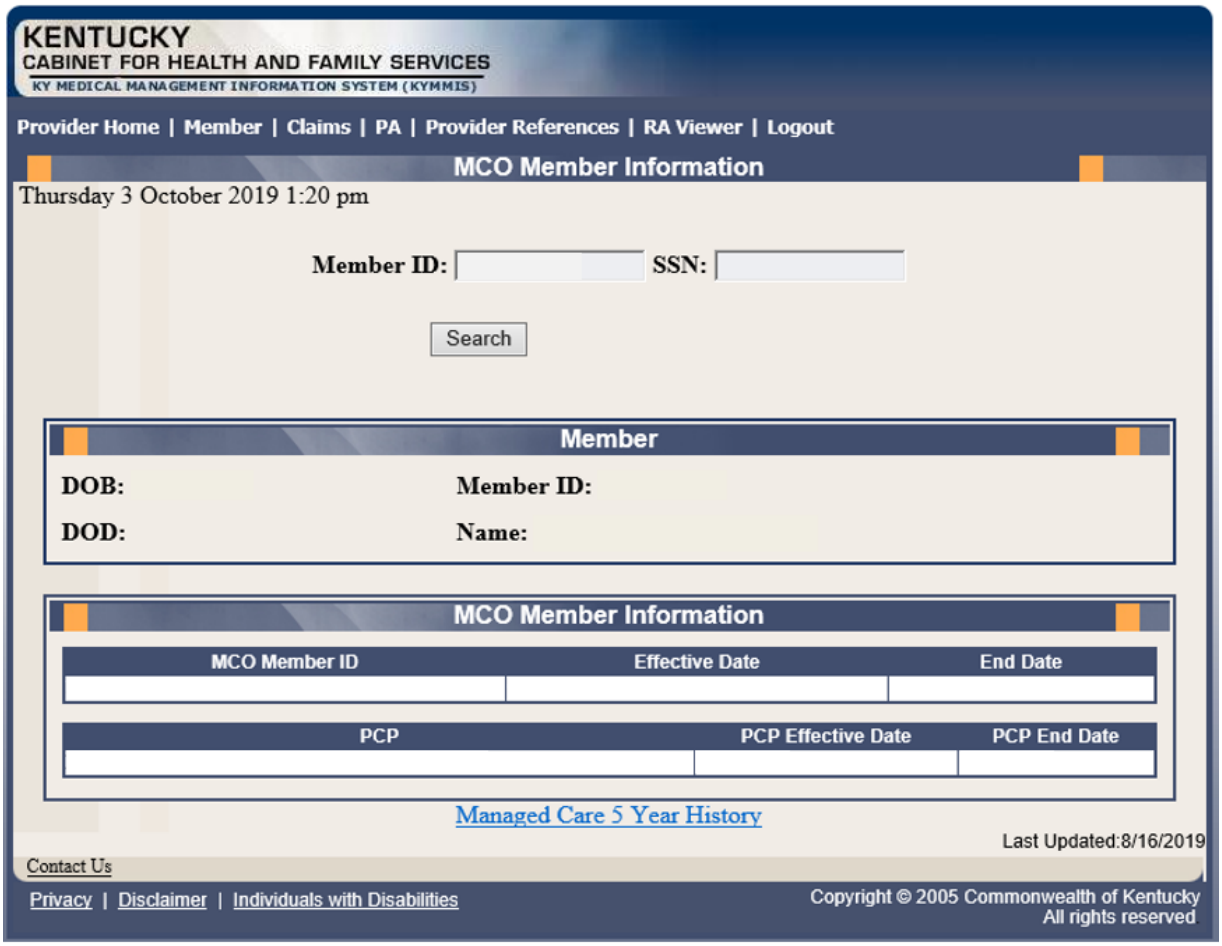
1. Select **Member** from the menu.
2. Choose **MCO Member Information** from the drop-down.

The following screen will appear.



3. Enter the member's Medicaid ID or SSN and click **Search**.

The member's MCO information will appear:

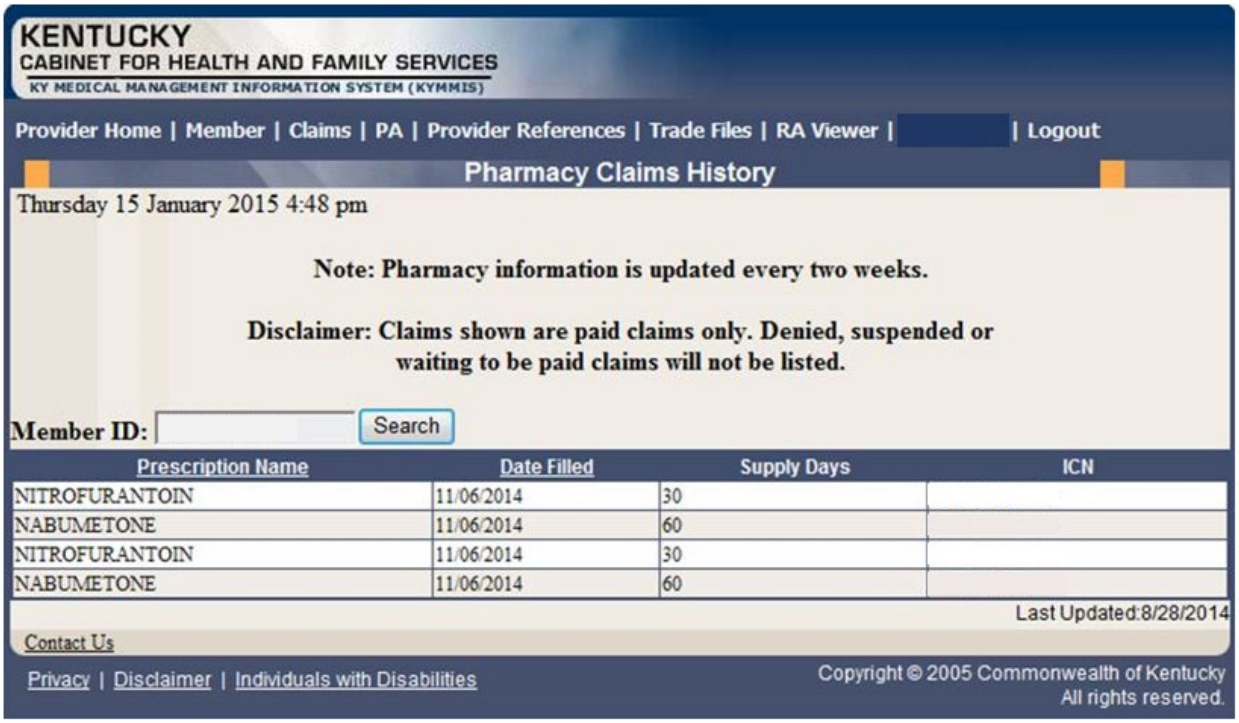


5.4 View Pharmacy Claim History

1. Select **Member** from the menu.
2. Choose **Pharmacy History** from the drop-down.

The following screen will appear.

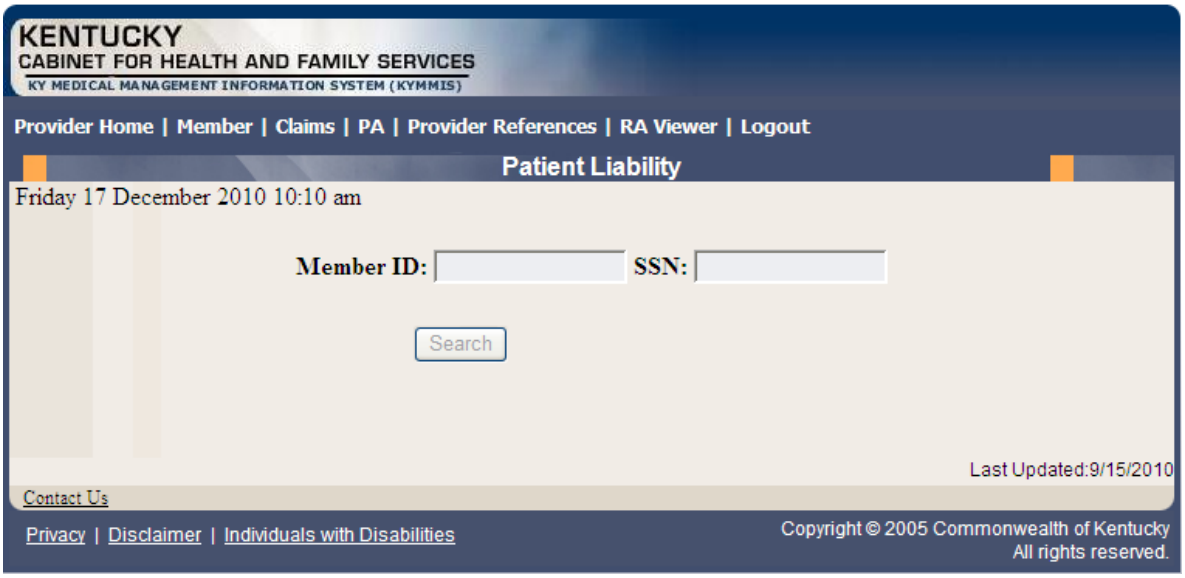
3. Enter the Member's ID and click **Search**.
4. The **Pharmacy Claims History** screen will appear.



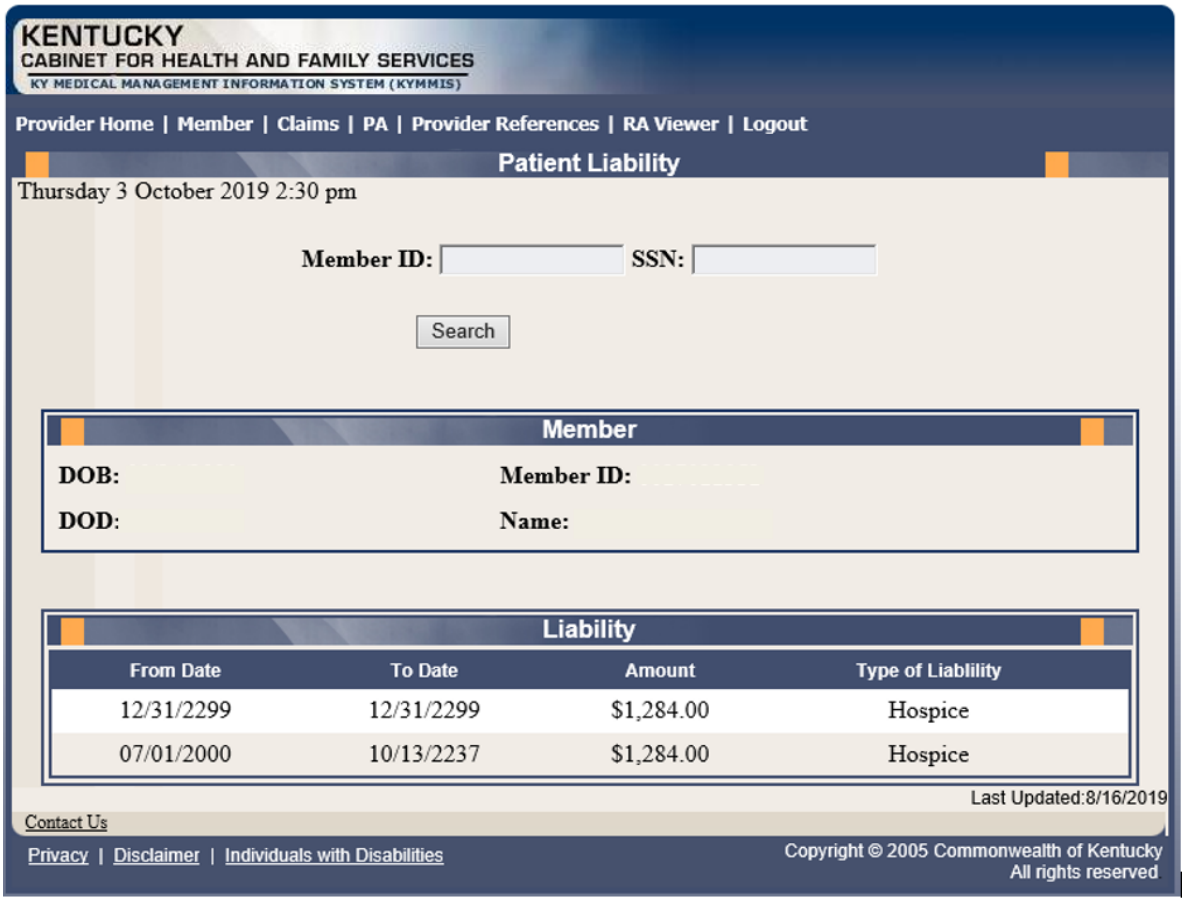
5.5 Patient Liability

1. Select **Member** from the menu.
2. Choose **Patient Liability** from the drop-down.

The following screen will appear.

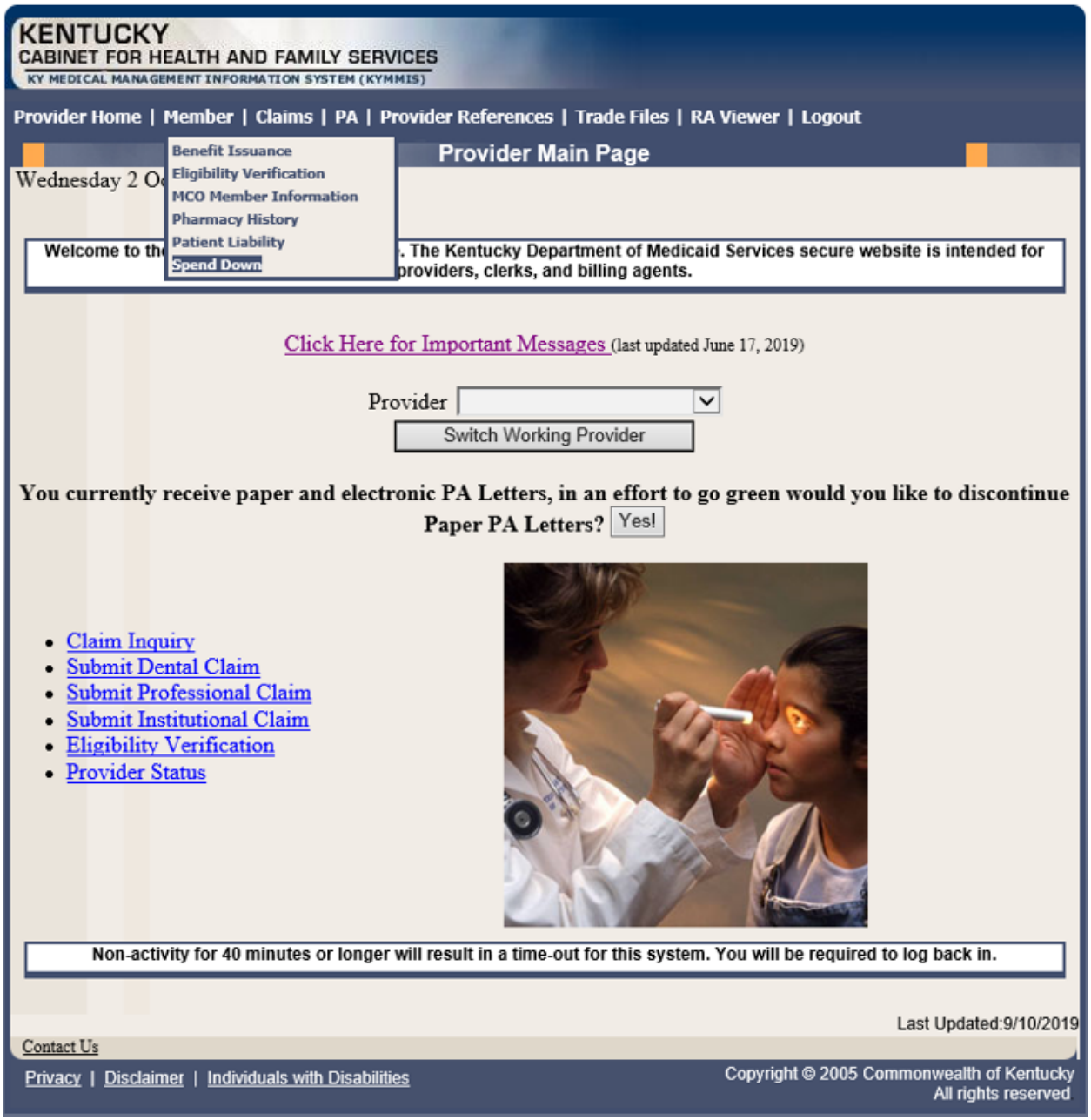


1. Enter the Member's ID or SSN and click **Search**.
2. The Member's patient liability information will appear.



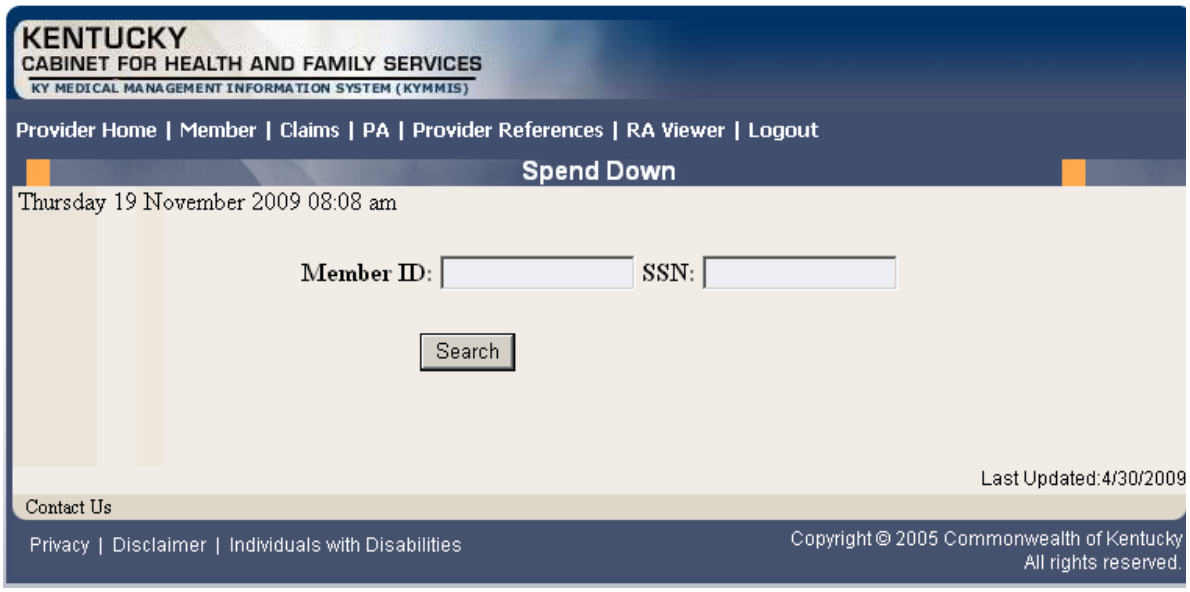
5.6 Spend Down

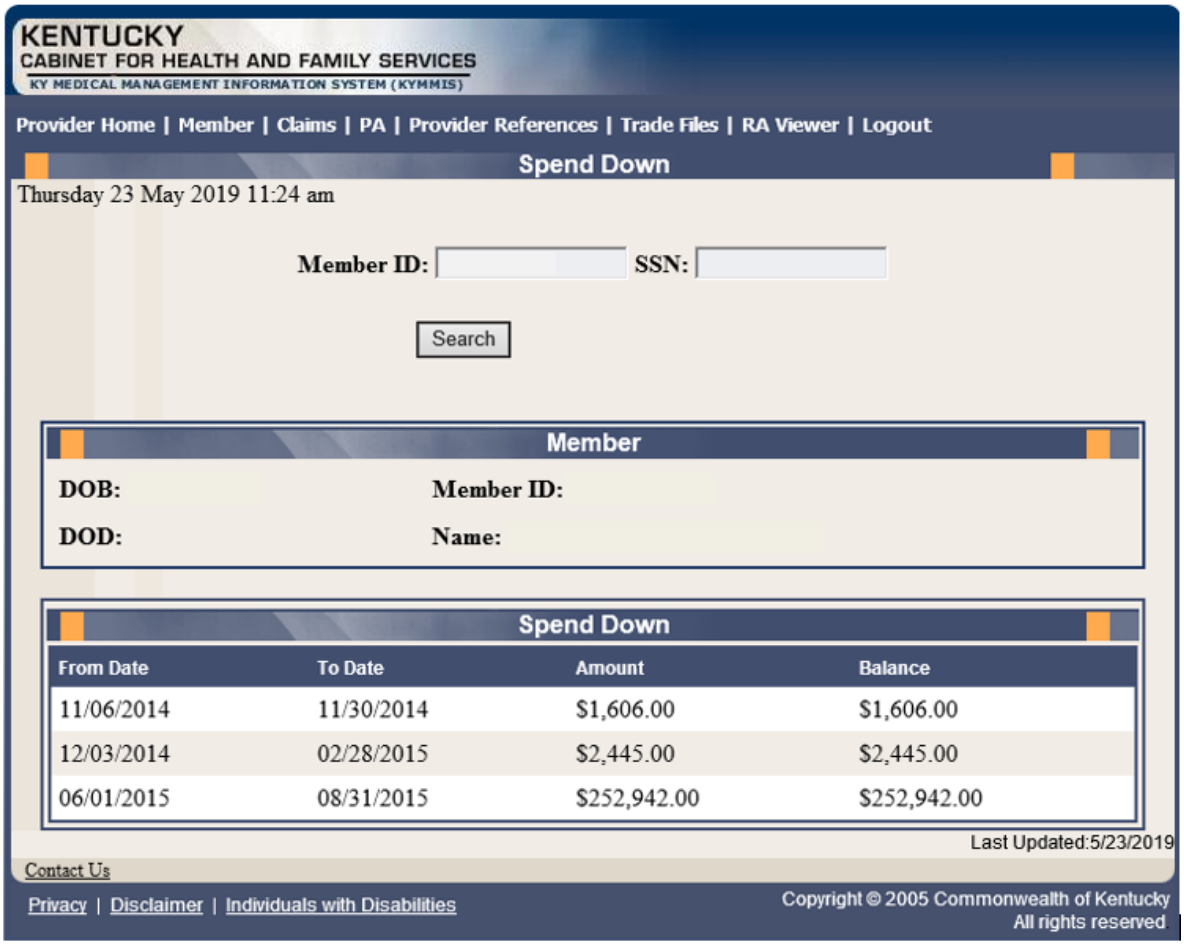
1. Select **Member** from the menu.
2. Choose **Spend Down** from the drop-down.



The following screen will appear.

3. Enter the Member ID or SSN and click the **Search** button to find the spend down data.

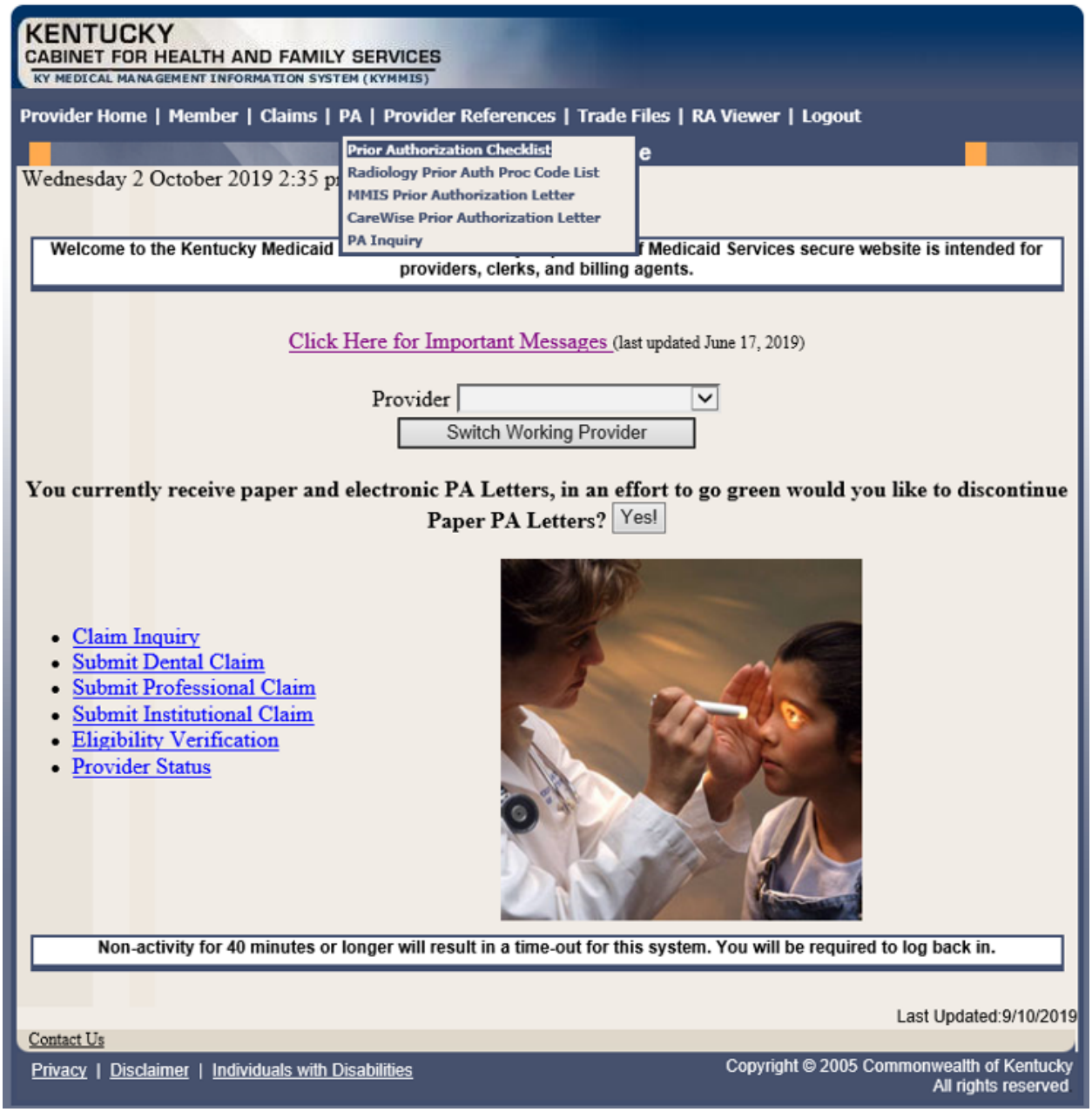




6 PA – Prior Authorization

6.1 Prior Authorization Checklist

1. Select **PA** from the menu.
2. Choose **Prior Authorization Checklist** from the drop-down.



3. The following page will appear with the prior authorization forms that are available for download. Click the link to open the document.

Kentucky.gov Search: ? Go Advanced Search

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
KY MEDICAID MANAGEMENT INFORMATION SYSTEM (KYMMIS)

kymmis > Provider Relations : PriorAuthorizationForms

Kentucky UNBRIDLED SPIRIT

Prior Authorization Forms

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F.A.Q.
Presumptive Eligibility
Provider Letters
Provider Workshop
Provider Billing Instructions
KY Health Net user manuals
Department for Medicaid Services
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Provider Directory
Provider Relations
Electronic Claims
HIPAA
Companion Guides and EDI Guides
Medicaid Preferred Drug List

Contact Information
If you need assistance, contact us by sending an e-mail to the following address:
KY EDI HelpDesk

Prior Authorization Forms are displayed in Adobe Acrobat formats.

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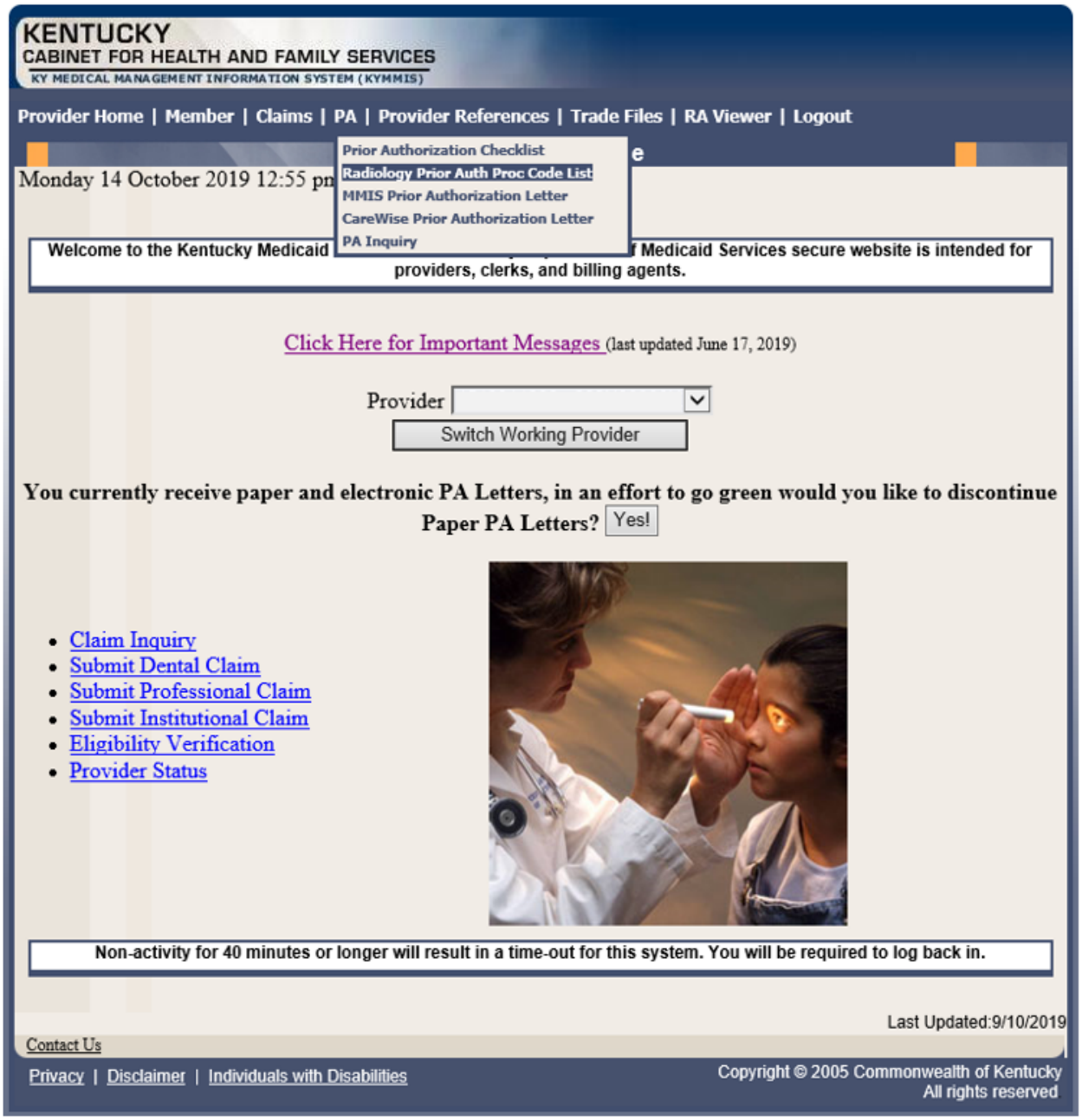
Form	Description	Last Revision Date
	Prior Authorization Checklist	June 2019
	Radiology Codes	Sept. 2006
	Independent Therapy Request Form	June 2018
	Obstetric Notification Form	Dec. 2009
MAP 5	EPSDT Dental Evaluation Form	March 2008
MAP 9	Prior Authorization for Health Services Instructions	July 2010
MAP 9A	Orthodonitc Services Agreement	June 2005
MAP 130	PA Fax Form	Sept. 2011
	Instructions for PA Fax	
MAP 249	MAP 249 PDN Clinical Review	April 2014
MAP 306	Temporomandibular Joint (TMJ) Assessment	June 2005
MAP 396	Orthodontic Evaluation	June 2005
MAP 414	Application for Approval of Nurse Aide Training Program	June 2005
MAP 556	Orthodontic Referral	June 2005
MAP 559	Six Month Orthodontic Progress	June 2005
MAP 569	Psychiatric Preadmission Review of Elective Admissions	June 2005
MAP 570	Certification of Need for Inpatient Psychiatric Svcs for Individuals under Age 21	June 2005
MAP 575	Request for Reconsideration of Resources Utilization Group Audit Determination	June 2005
Map 576	Nurse Aide Training Expense Report and Authorization for Payment Instructions	July 2012
MAP 650	Home Health Fax Form 2009	Nov. 2008
MAP 700	Orthodontic Final Case Submission	June 2005
MAP 703	Request for Reconsideration Ancillary Therapy Billing	March 2014
MAP 726A	Nursing Facility Request for Admission	Sept. 2003
MAP 1000	Certificate of Medical Necessity - Durable Medical Equipment	July 2010

6.2 Radiology Prior Authorization Procedure Code List

1. Select **PA** from the menu.
2. Choose **Radiology Prior Auth Proc Code List** from the drop-down.



3. The following page will appear with the prior authorization forms that are available for download. Click the link to open the document.

Kentucky.gov Search: ? Go Advanced Search

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Provider Billing Instructions
KY Health Net user manuals
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HIPAA
Companion Guides and EDI Guides
Medicaid Preferred Drug List

Contact Information
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KY EDI HelpDesk

Prior Authorization Forms are displayed in Adobe Acrobat formats.

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Form	Description	Last Revision Date
	Prior Authorization Checklist	June 2019
	Radiology Codes	Sept. 2006
	Independent Therapy Request Form	June 2018
	Obstetric Notification Form	Dec. 2009
MAP 5	EPSDT Dental Evaluation Form	March 2008
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MAP 9A	Orthodonitc Services Agreement	June 2005
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	Instructions for PA Fax	
MAP 249	MAP 249 PDN Clinical Review	April 2014
MAP 306	Temporomandibular Joint (TMJ) Assessment	June 2005
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MAP 559	Six Month Orthodontic Progress	June 2005
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MAP 570	Certification of Need for Inpatient Psychiatric Svcs for Individuals under Age 21	June 2005
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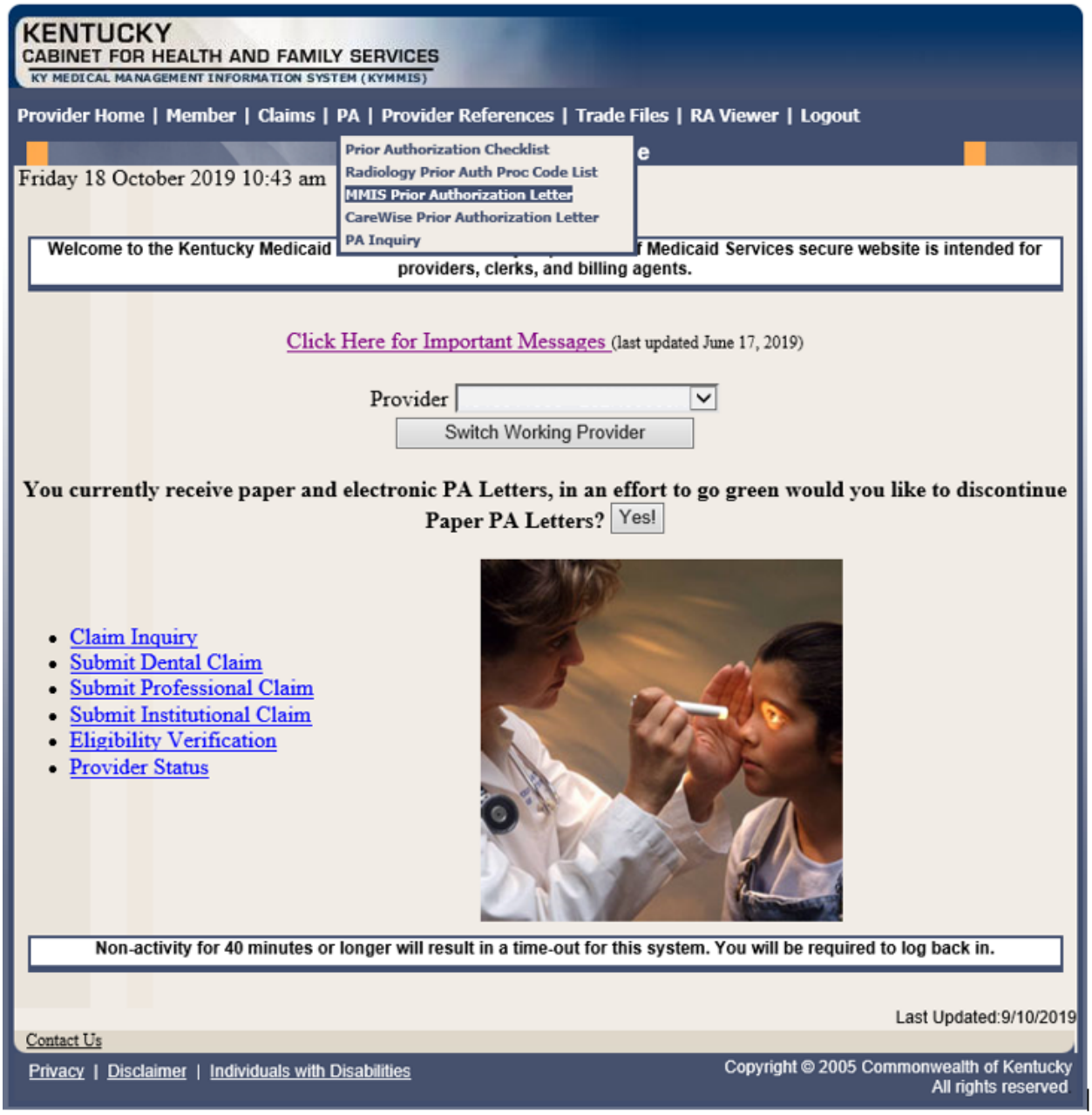
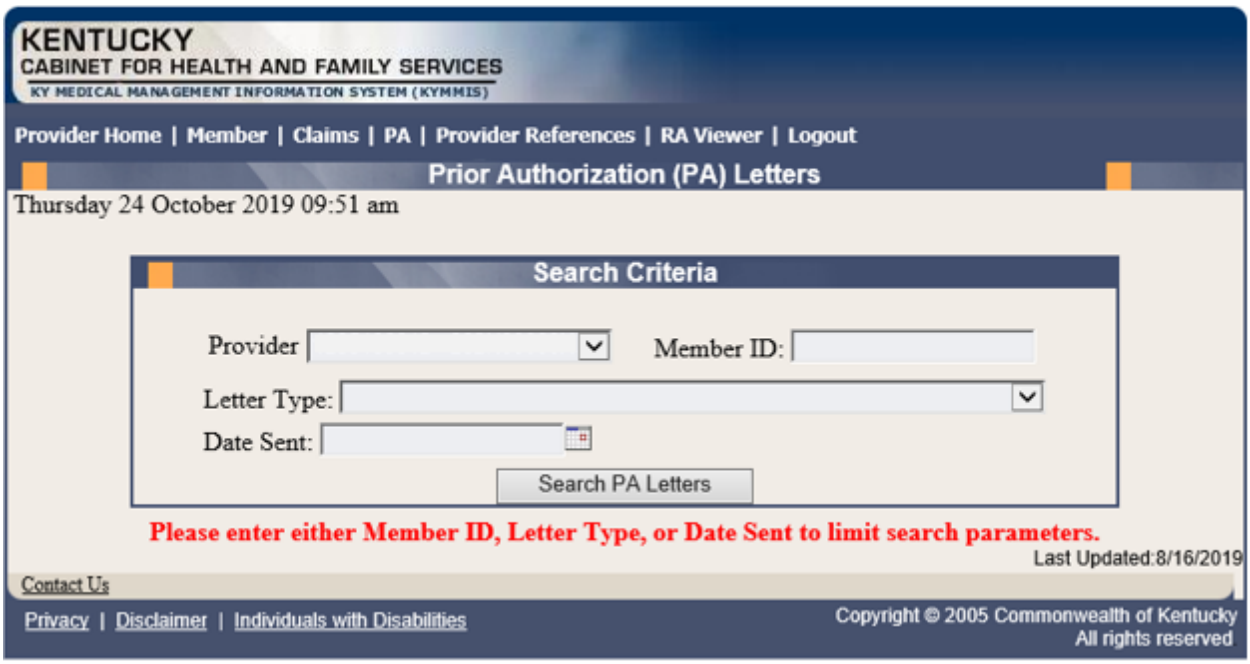
Map 576	Nurse Aide Training Expense Report and Authorization for Payment Instructions	July 2012
MAP 650	Home Health Fax Form 2009	Nov. 2008
MAP 700	Orthodontic Final Case Submission	June 2005
MAP 703	Request for Reconsideration Ancillary Therapy Billing	March 2014
MAP 726A	Nursing Facility Request for Admission	Sept. 2003
MAP 1000	Certificate of Medical Necessity - Durable Medical Equipment	July 2010

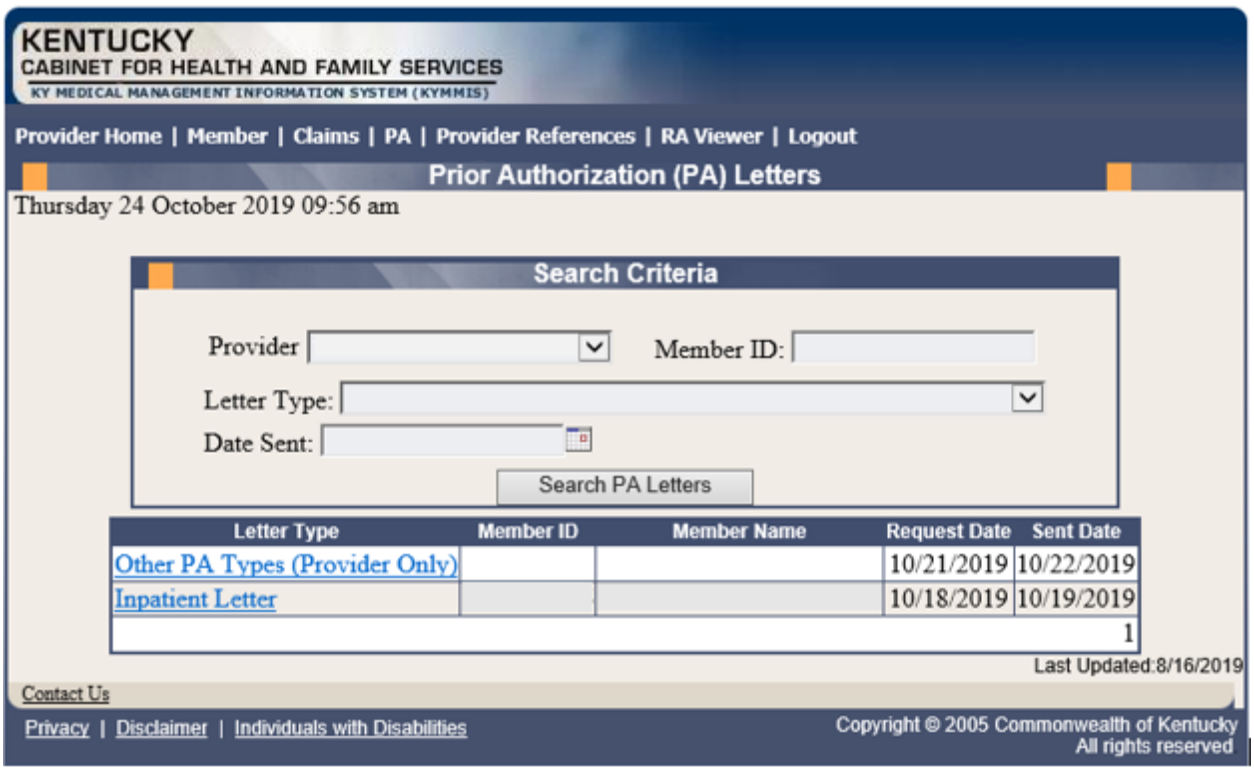
6.3 MMIS PA Letters

1. Select **PA** from the menu.
2. Choose **MMIS Prior Authorization Letter** from the drop-down.





3. Enter Member ID, Letter Type, or Date Sent criteria and press the **Search PA Letters** button.

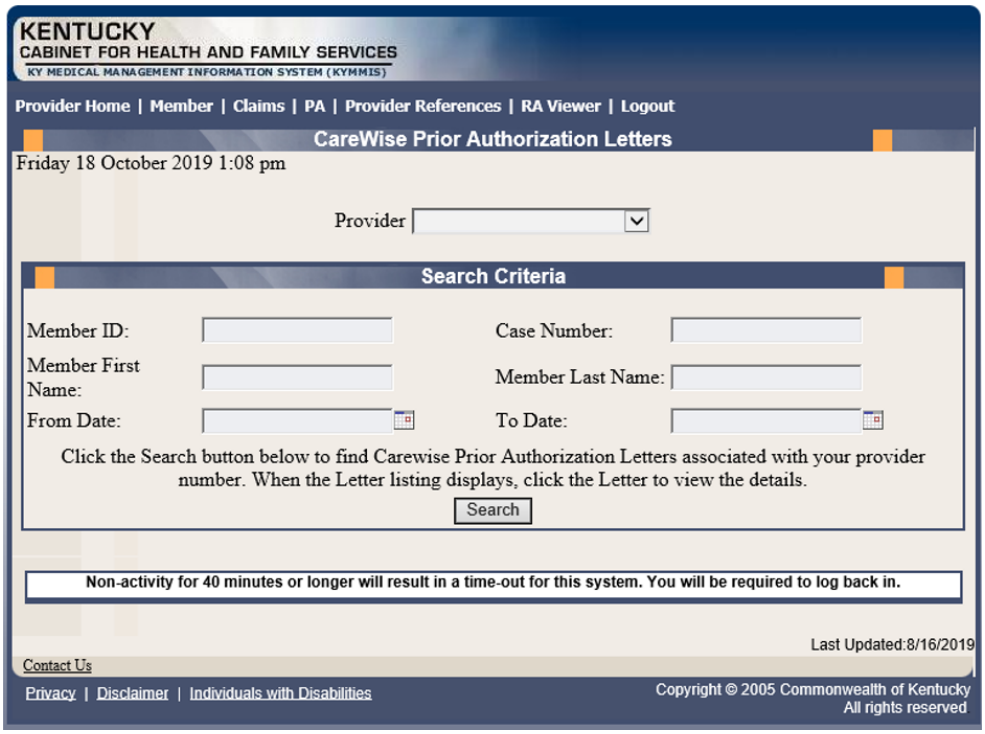


4. Click the link of the letter to generate a PDF to view, download, or print.

6.4 CareWise PA Letters

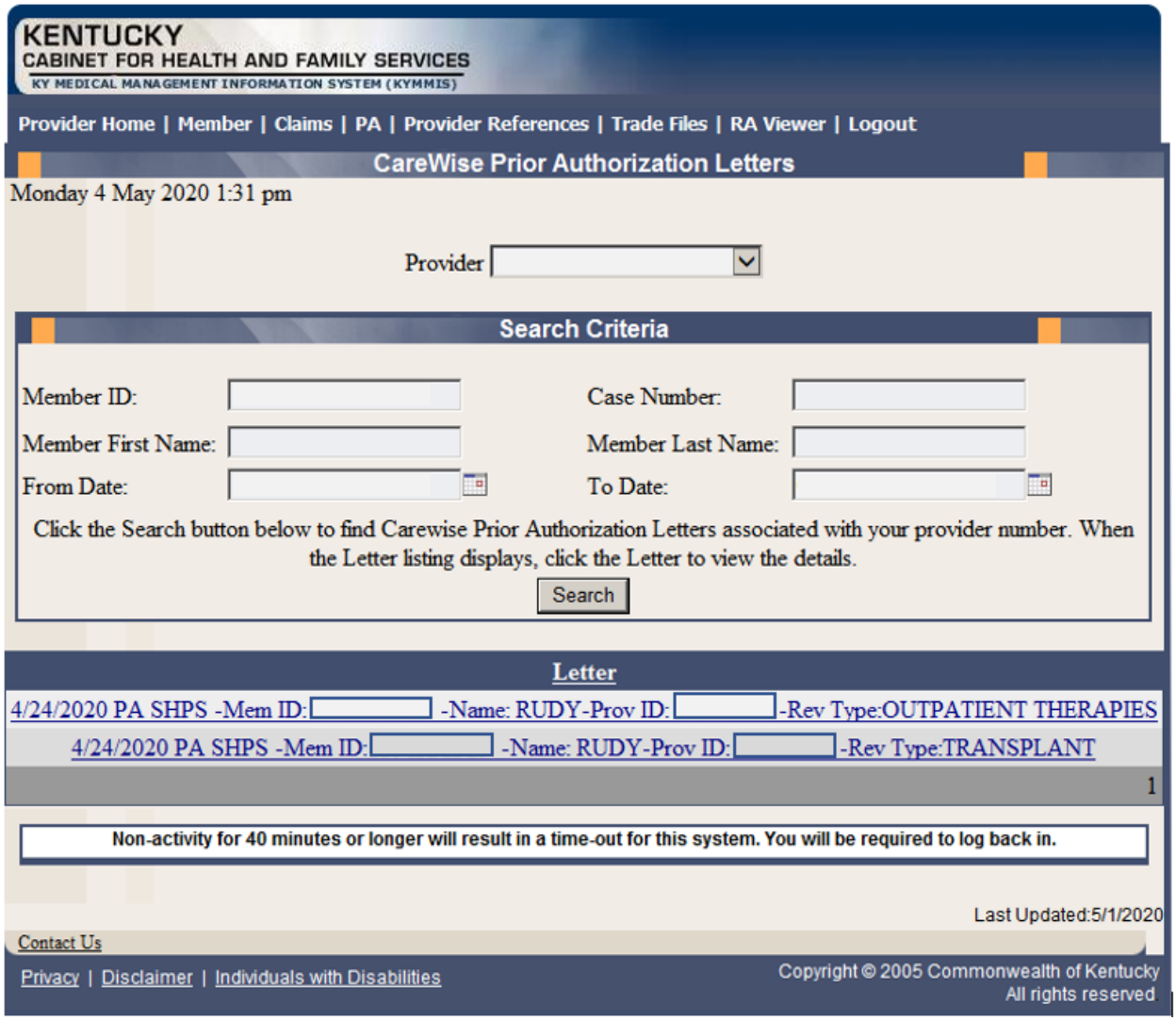
1. Select **PA** from the menu.
2. Choose **CareWise Prior Authorization Letter** from the drop-down.

The following screen will appear.



The Member ID, From Date, and To Date are required to perform a search.

3. Enter the search criteria and press the **Search** button.


KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
KY MEDICAL MANAGEMENT INFORMATION SYSTEM (KYMMIS)
Provider Home | Member | Claims | PA | Provider References | Trade Files | RA Viewer | Logout
CareWise Prior Authorization Letters
Monday 4 May 2020 1:31 pm
Provider
Search Criteria
Member ID:
Case Number:
Member First Name:
Member Last Name:
From Date:
To Date:
Click the Search button below to find Carewise Prior Authorization Letters associated with your provider number. When the Letter listing displays, click the Letter to view the details.
Search
Letter
4/24/2020 PA SHPS -Mem ID: -Name: RUDY-Prov ID: -Rev Type:OUTPATIENT THERAPIES
4/24/2020 PA SHPS -Mem ID: -Name: RUDY-Prov ID: -Rev Type:TRANSPLANT
1
Non-activity for 40 minutes or longer will result in a time-out for this system. You will be required to log back in.
Last Updated:5/1/2020
Contact Us
Privacy | Disclaimer | Individuals with Disabilities
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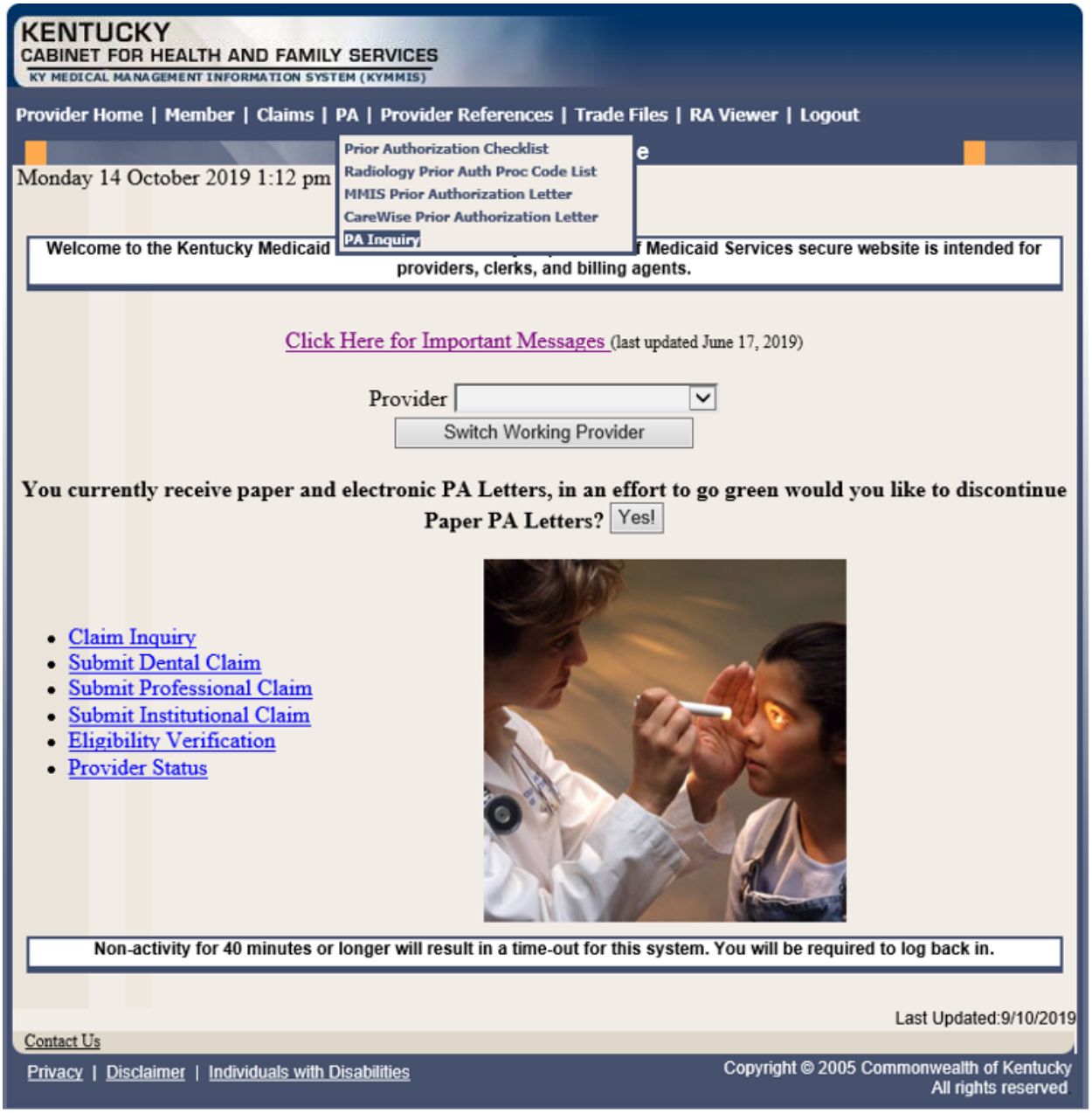
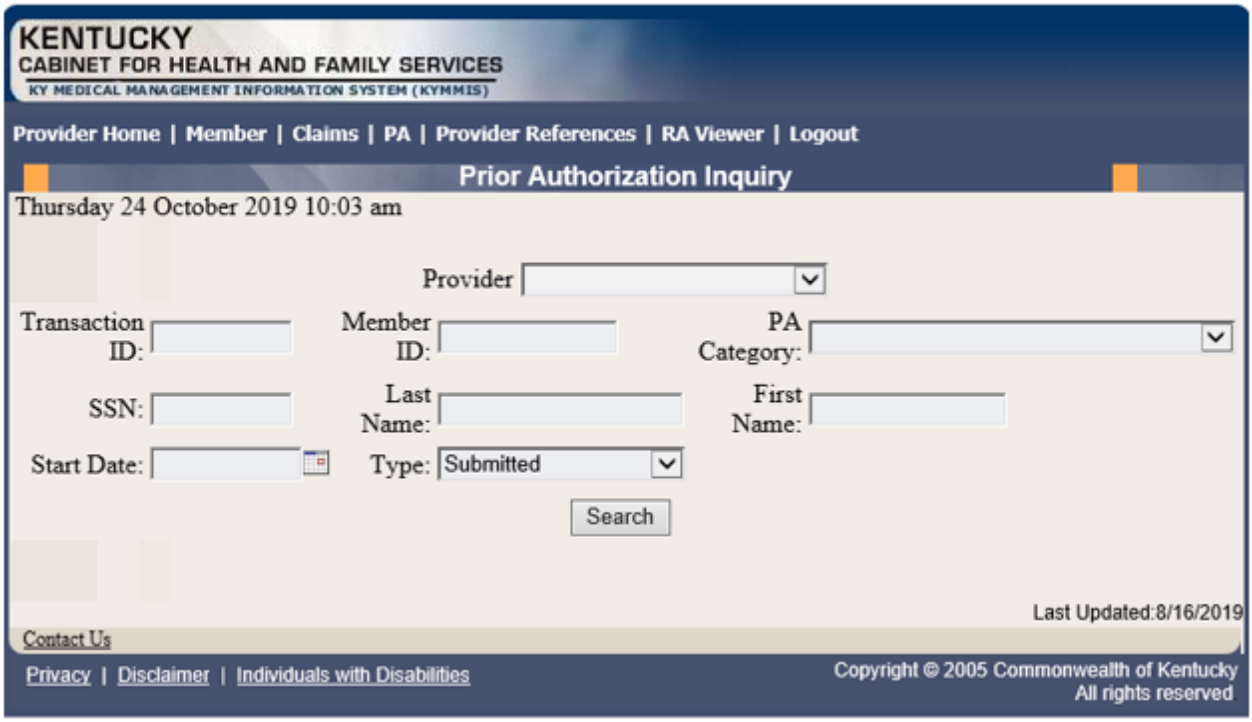
6.5 PA Inquiry

1. Select **PA** from the menu.
2. Choose **PA Inquiry** from the drop-down.



The following screen will appear.



A PA search is completed by entering:

- Transaction ID – is the PA number

or

- Member ID

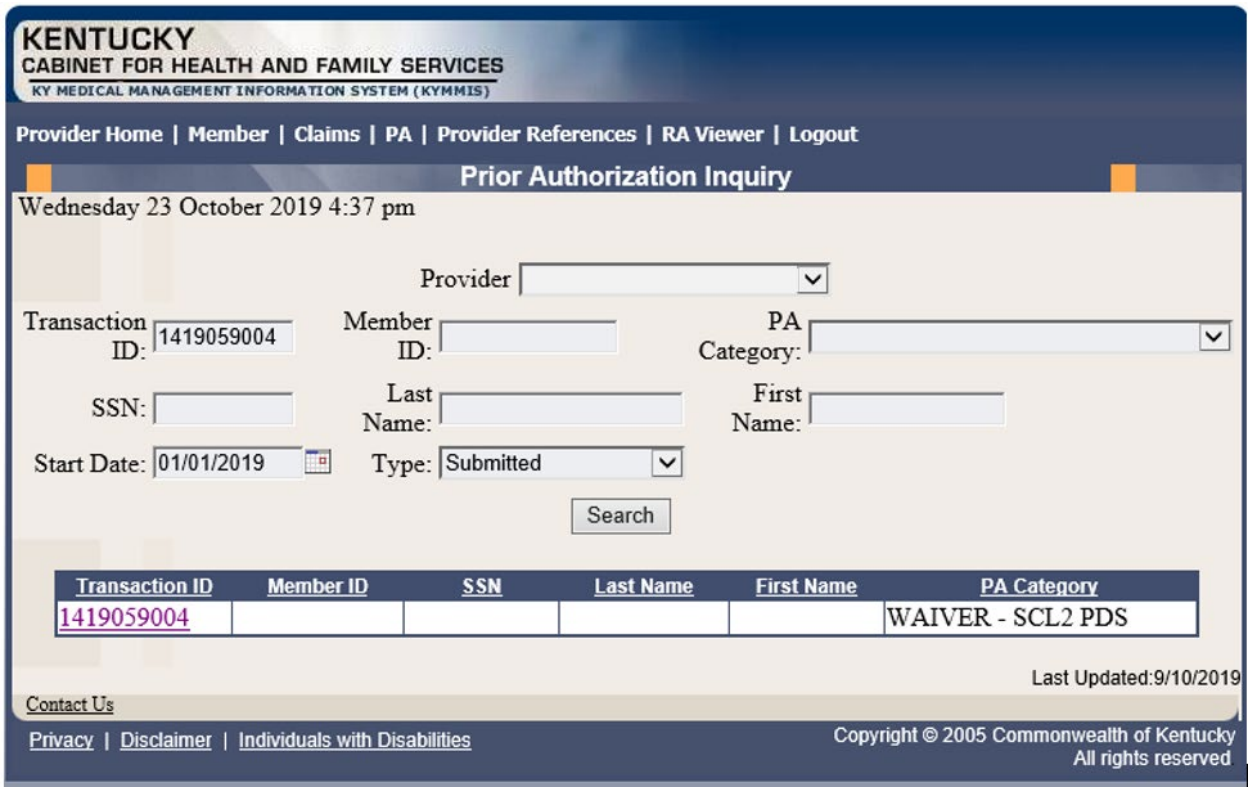
or

- SSN

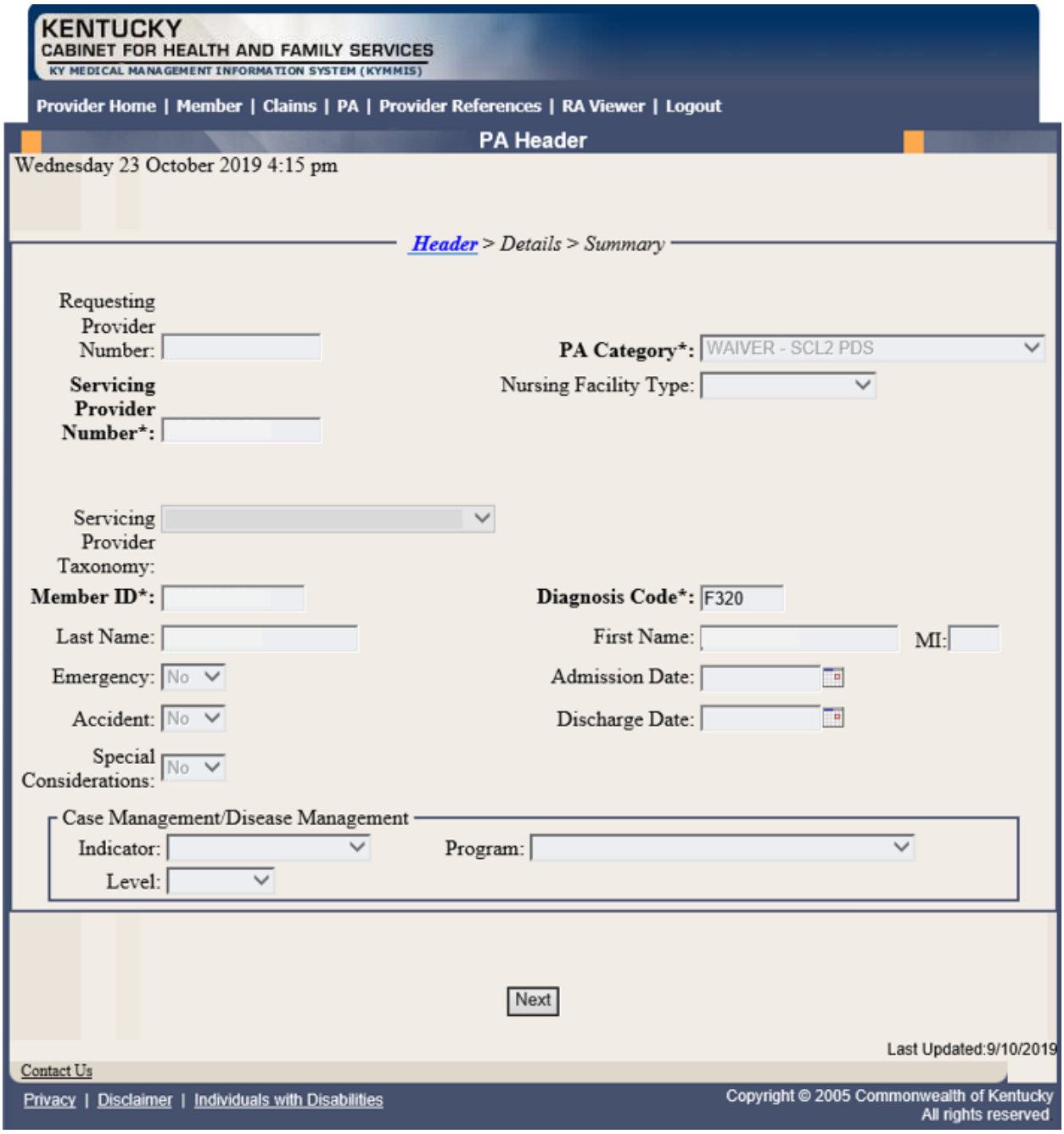
or

- Name of member
- Start Date is required with all search criteria.

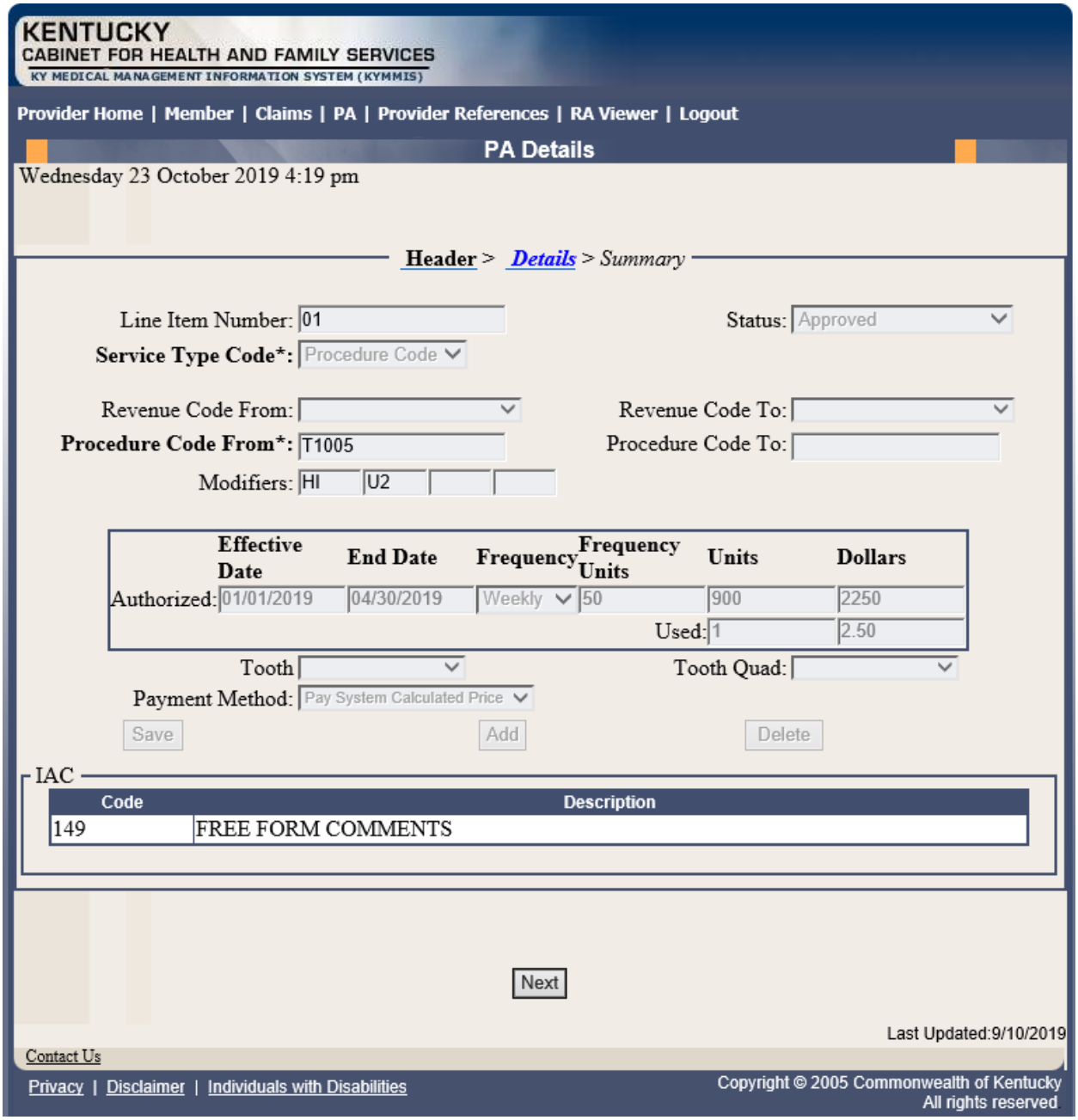
3. Select **Search** to return the results.



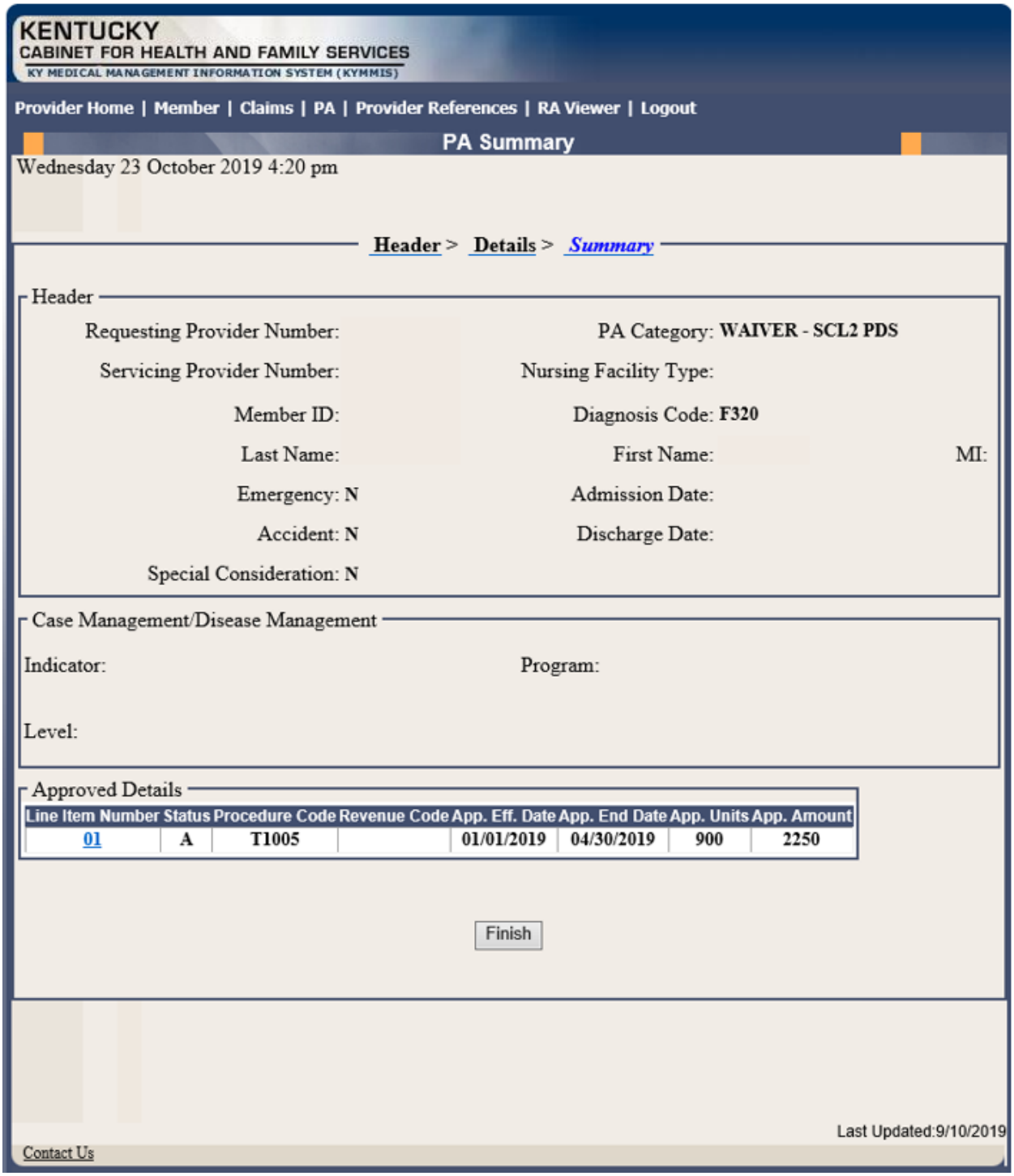
4. Click the **Transaction ID** link to open the **PA Header** page.



5. Click the **Next** button to view the **Details** page.



6. Click the **Next** button to view the **Summary** page.



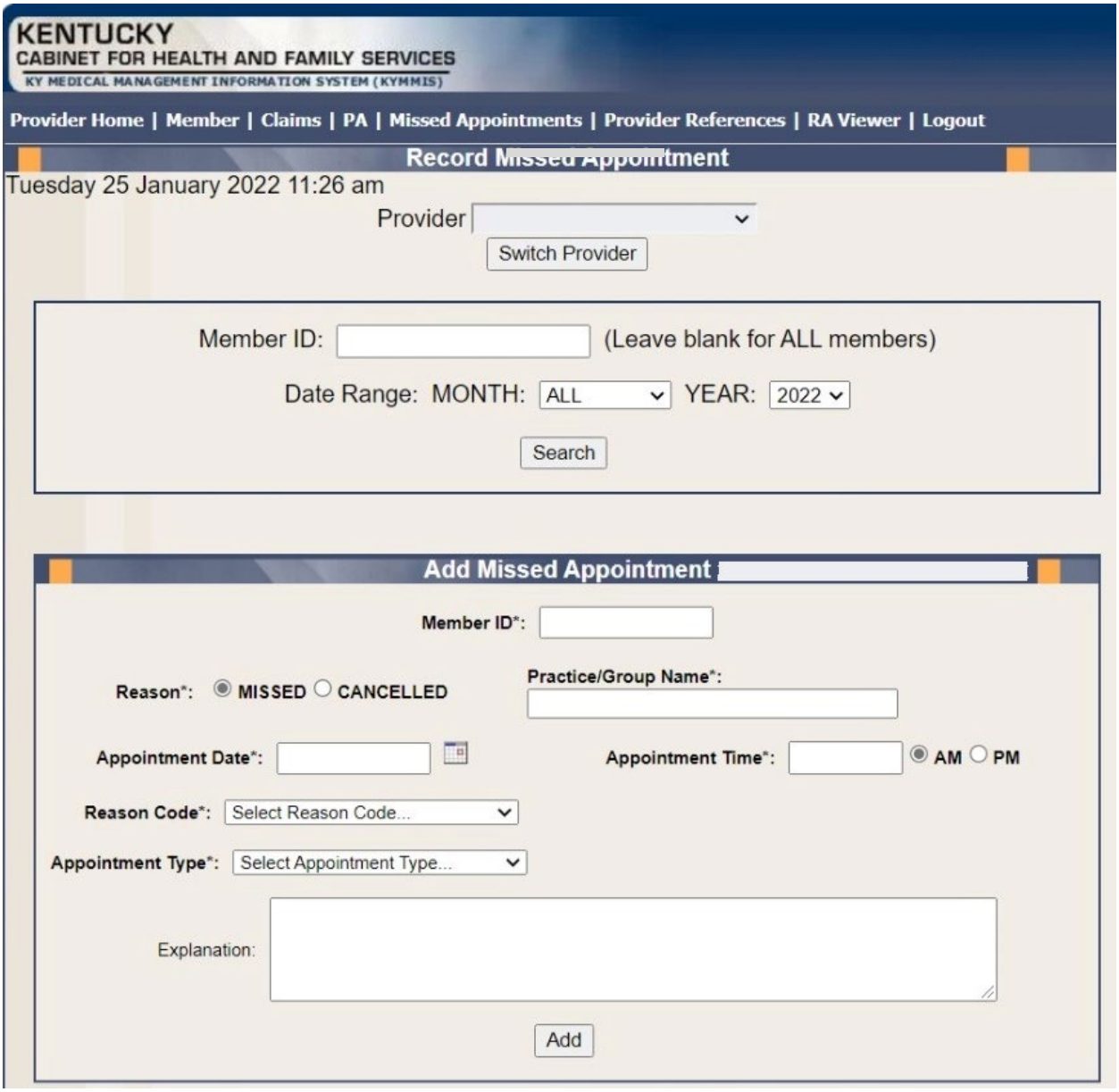
7. Click the **Finish** button to return to the **PA Inquiry** search page.

7 Missed Appointments

7.1 Record Missed Appointments

8. Select **Missed Appointments** from the menu.
9. Select **Record Missed Appointments** from the drop-down.

7.1.1 Add a missed appointment



Enter the following fields:

- Member ID: KY Medicaid member (required field, the system validates the member number).
- Reason - Missed or Cancelled (Missed is the system default).
- Practice/Group Name – required field
- Reason Code - Select the reason code from the dropdown list.

  Dropdown box options:

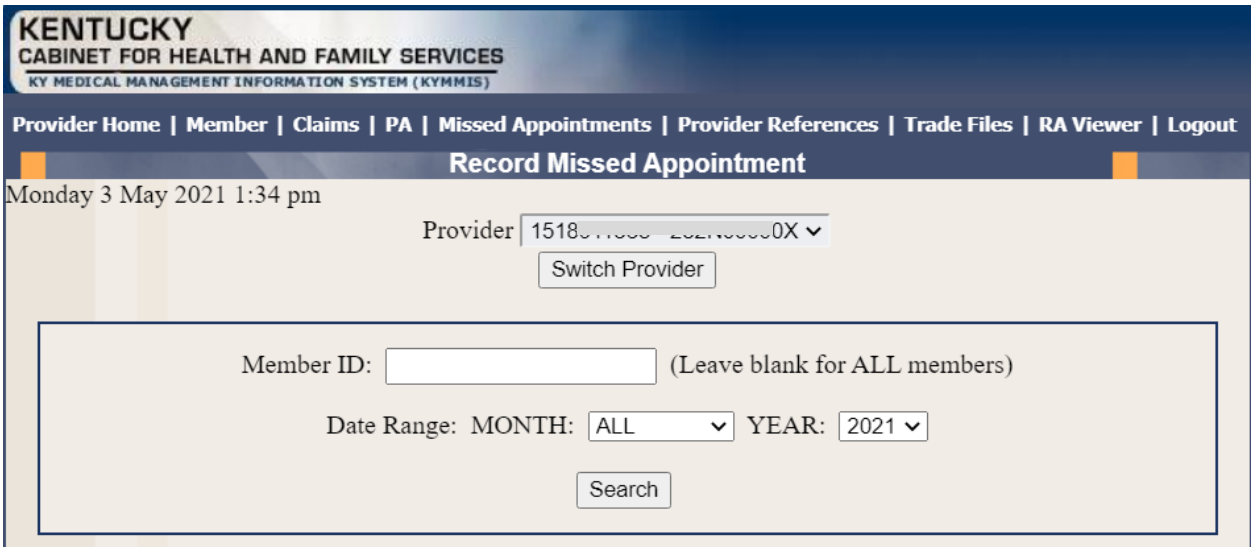
  - Child Care Issue
  - Transportation Issue

- Financial Issue
- Insurance Issue
- Unforeseen Issue
- Forgot About Appointment
- Unknown
- Other-Please Provide Explanation Below

- Appointment Date - Field is required. Manual entry, MM/DD/YYYY or Select the calendar icon to auto-populated a date.
  If 'Missed' is selected from the reason field, the date range selection is previous date to current date. User cannot select a future date.
  If 'Cancelled' is selected from the reason field, the date range selection is open. User can use previous, current, or future date.
- Appointment Time- Field is required
  Manual entry, user must use HH:MM format
  - AM: Radio Button (default option)- Field is not validated. User must manually select option.
  - PM: Radio Button: Field is not validated. User must manually select option
- Appointment Type- Select the appointment type from the dropdown list.
  - Select Appointment Type (Default Option)
  - PCP
  - Behavioral Health Therapy
  - Outpatient Program
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy
  - Applied Behavioral Therapy
  - Other Therapy
  - Dental
  - Vision
  - Specialist
- Specialist Type – Text box displays if Specialist is selected from the Appointment Type dropdown list.
- Explanation: Enter an explanation. Open Text field with a 200-character maximum.
  Note: Field is only required if 'Other-Please Provider Explanation Below' is the selected reason code.
- Add: The Add button allows the system to update the record.

7.1.2 Search for a Missed or Cancelled Appointment

The member data below is mocked up from our test environment and doesn't contain any true PHI



Enter the following fields:

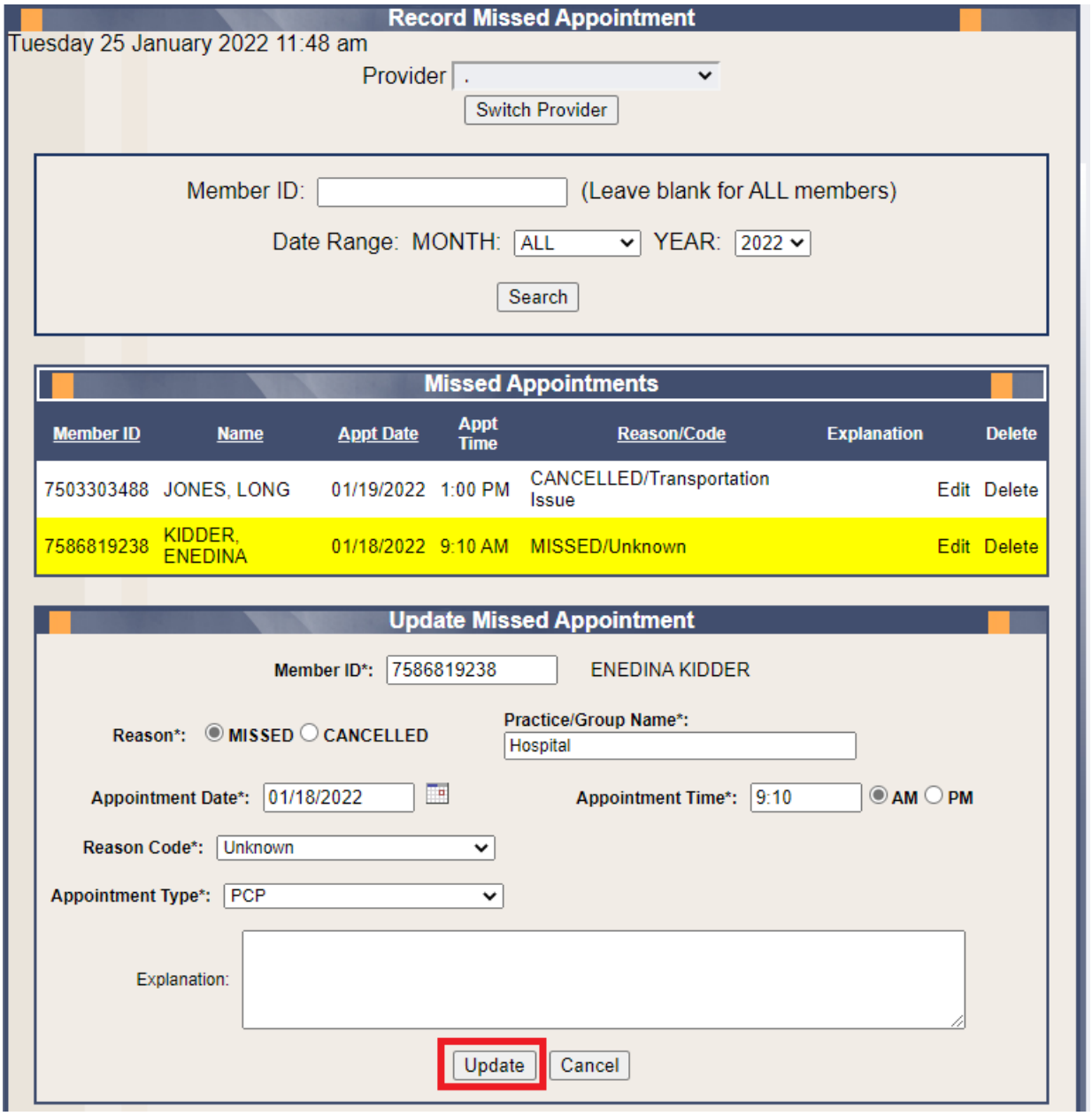
- Member ID- If searching for one member or leave blank to return appointments for all members.
- Date Range-
  Month: Select All for all months within the year selected or select a particular month.
  Year: Select the year
- Search- Returns results

Missed Appointments

Member ID	Name	Appt Date	Appt Time	Reason/Code	Explanation	Delete
8572928103	PIERCE, STEVIE	03/11/2021	11:00 AM	CANCELLED/Unforeseen Issue		Edit Delete
8572710403	BALLING, ILDA	03/10/2021	10:00 AM	CANCELLED/Financial Issue		Edit Delete
8572710403	BALLING, ILDA	03/04/2021	9:00 AM	CANCELLED/Financial Issue		Edit Delete
7503303488	JONES, LONG	02/23/2021	10:00 AM	MISSED/Child Care Issue	Test	Edit Delete

7.1.3 Edit a record

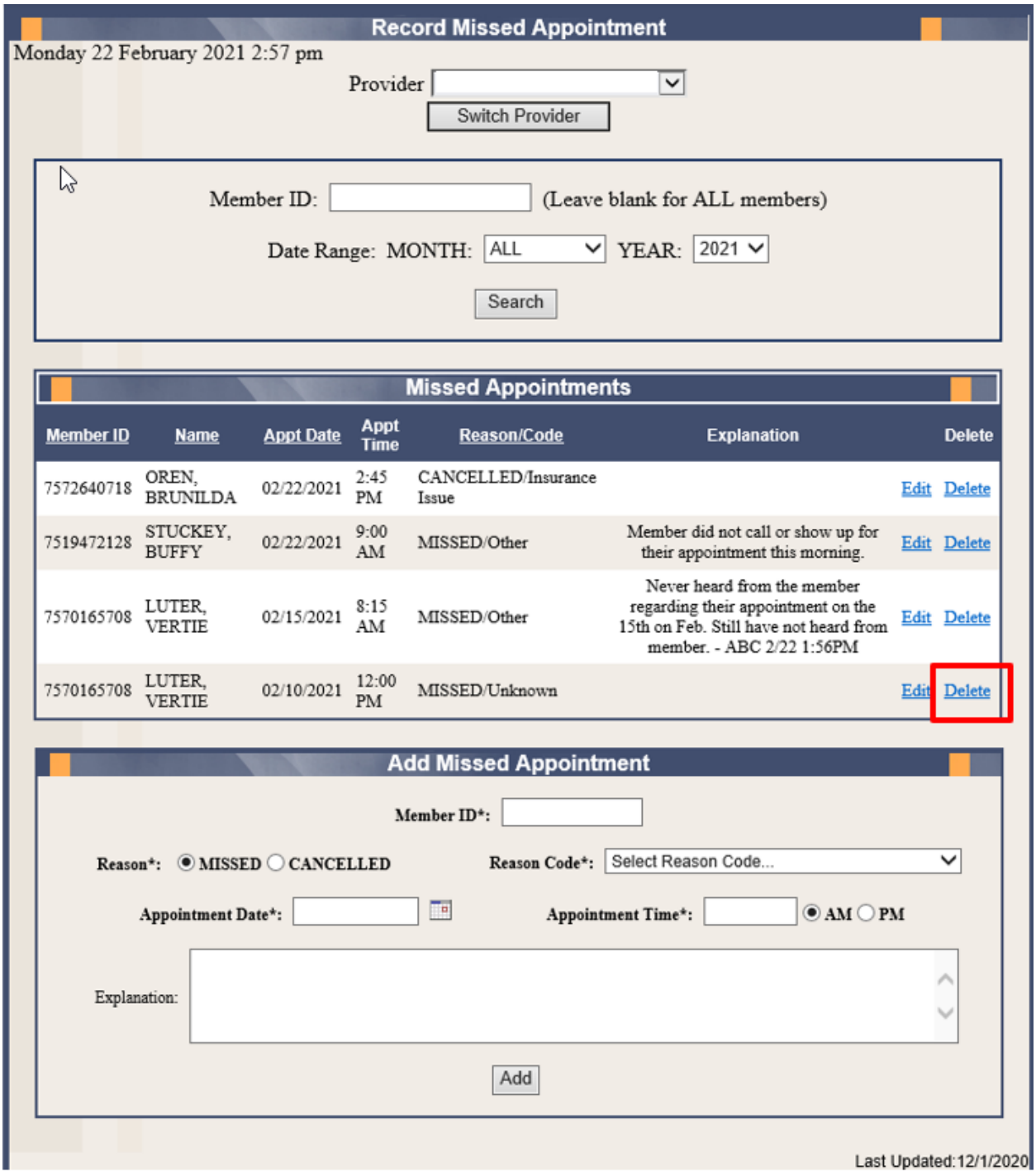
Edit a record can only be made by the provider who entered the missed/cancelled appointment.
Select Edit



- The record will refresh with a yellow highlight to indicate the line to edit.
- Enter the updated information as applicable.
- Click the Update button.

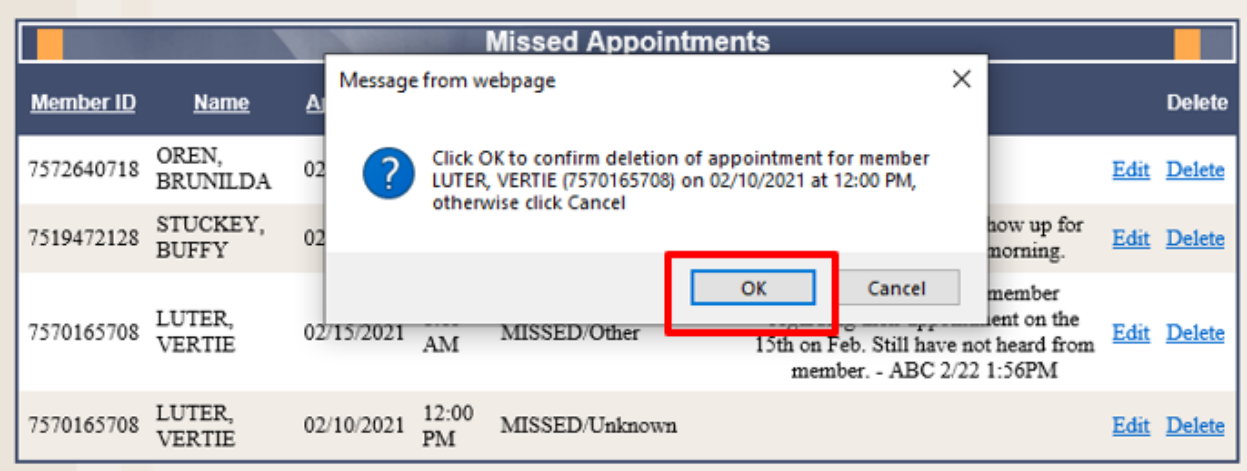
7.1.4 Delete a record

Delete a record can only be made by the provider who entered the missed/cancelled appointment. Select Delete.

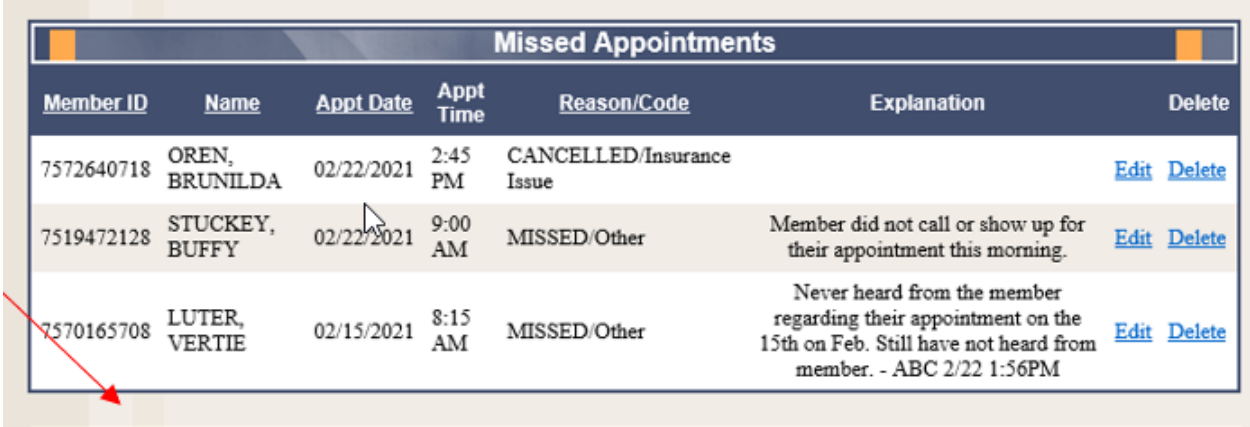


A message box will display confirming the record selected for deletion.

Select OK to remove record or cancel to retain the record.



Once OK is selected the appointment record is deleted.



7.1.5 Record Display

The system will display 5 records per screen. If there are more than 5 records an additional page is created systemically. Additional page count will appear in the lower right-hand side of the screen.

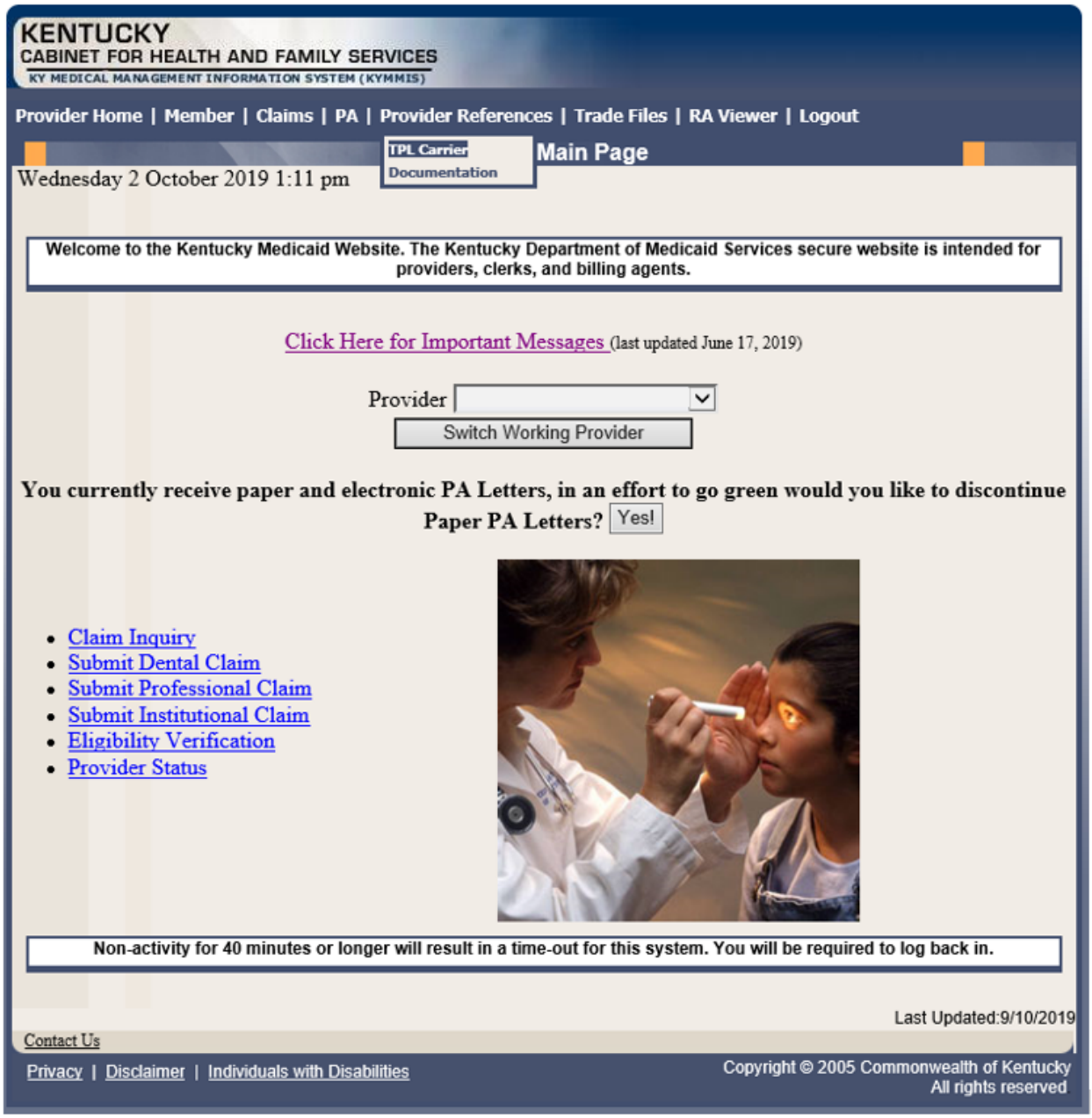
	Appt Date	Appt Time	Reason/Code	Explanation		Delete
VIE	03/11/2021	11:00 AM	CANCELLED/Unforeseen Issue		Edit	Delete
DA	03/10/2021	10:00 AM	CANCELLED/Financial Issue		Edit	Delete
DA	03/04/2021	9:00 AM	CANCELLED/Financial Issue		Edit	Delete
G	02/23/2021	10:00 AM	MISSED/Child Care Issue	Test	Edit	Delete
VIE	02/17/2021	3:00 PM	MISSED/Unforeseen Issue	Test	Edit	Delete

1 2

8 Provider References

8.1 TPL Carrier

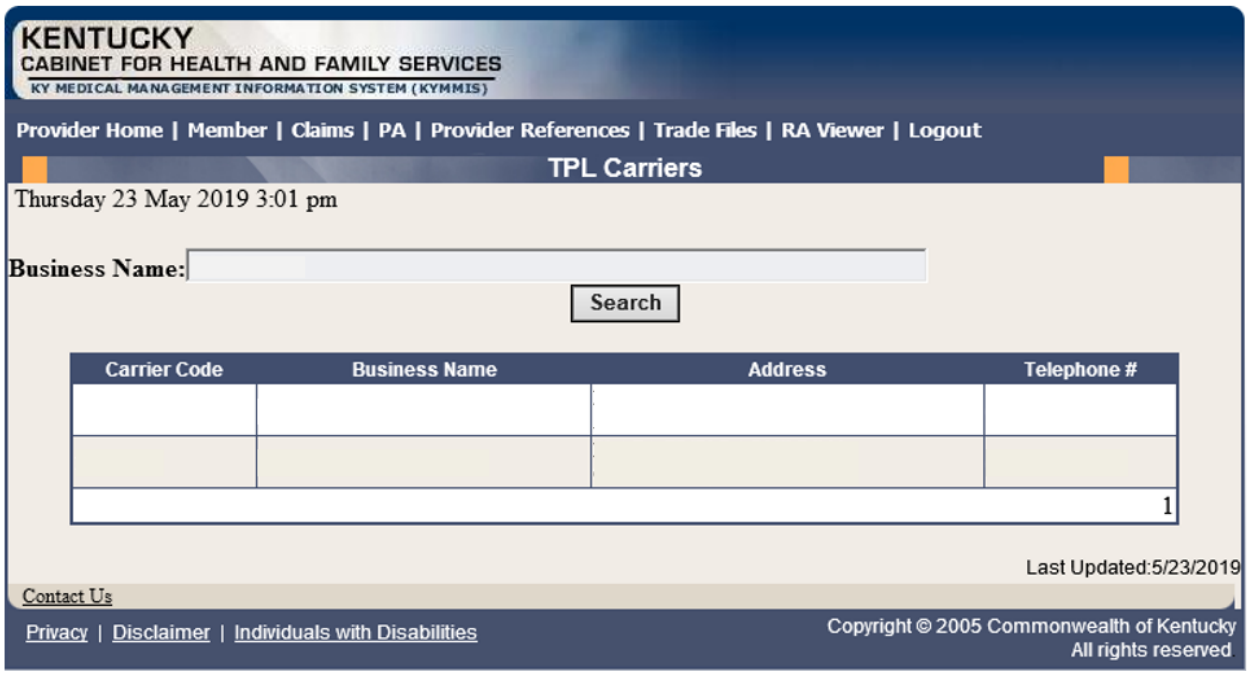
1. Select **Provider References** from the menu.
2. Choose **TPL Carrier** from the drop-down.



The following screen will appear.

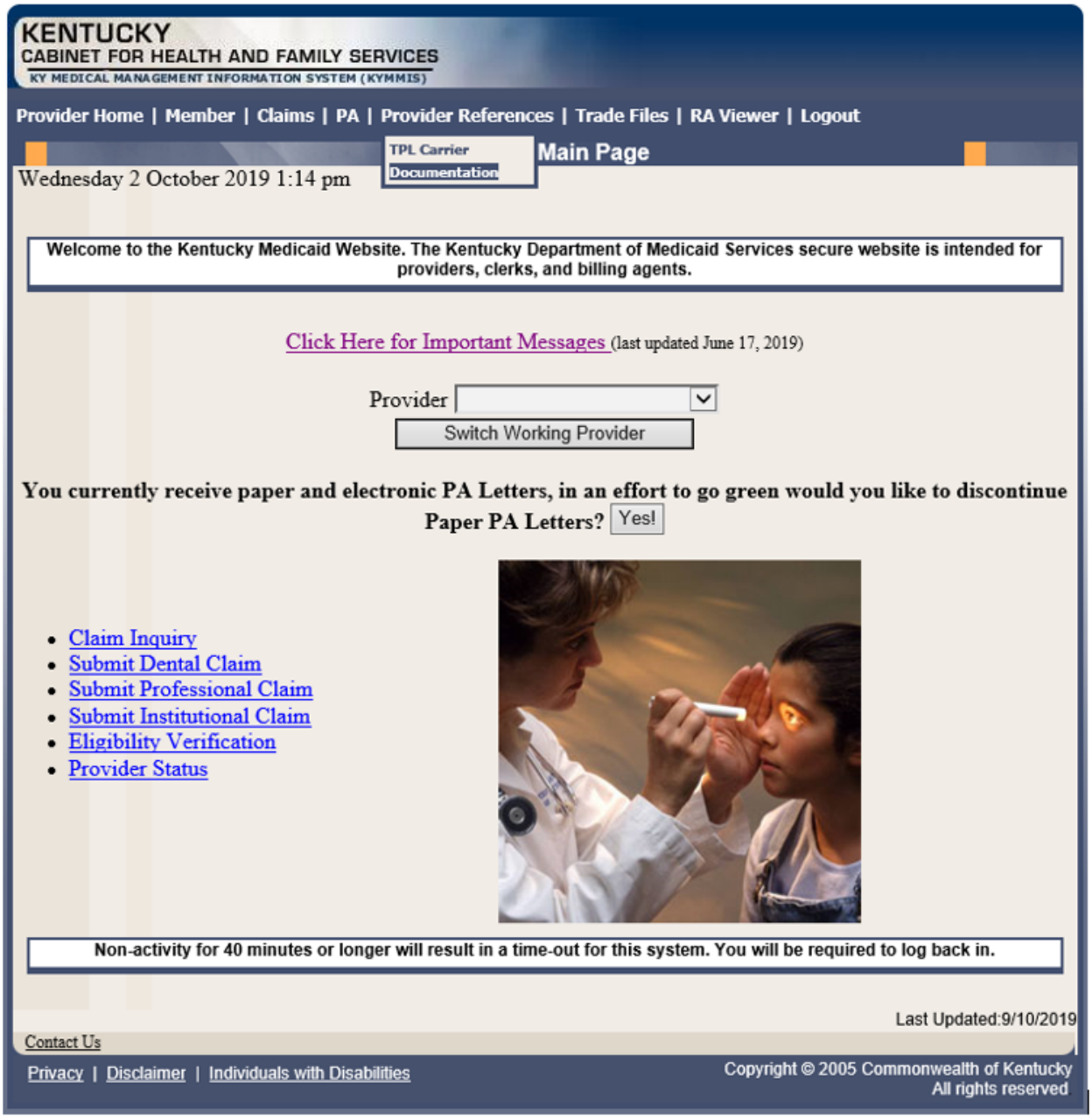
3. Enter the TPL Carrier name.
4. Click **Search**.

The response will return all carrier information on file.



8.2 Provider References Documentation

1. Select **Provider References** from the menu.
2. Choose **Documentation** from the drop-down.

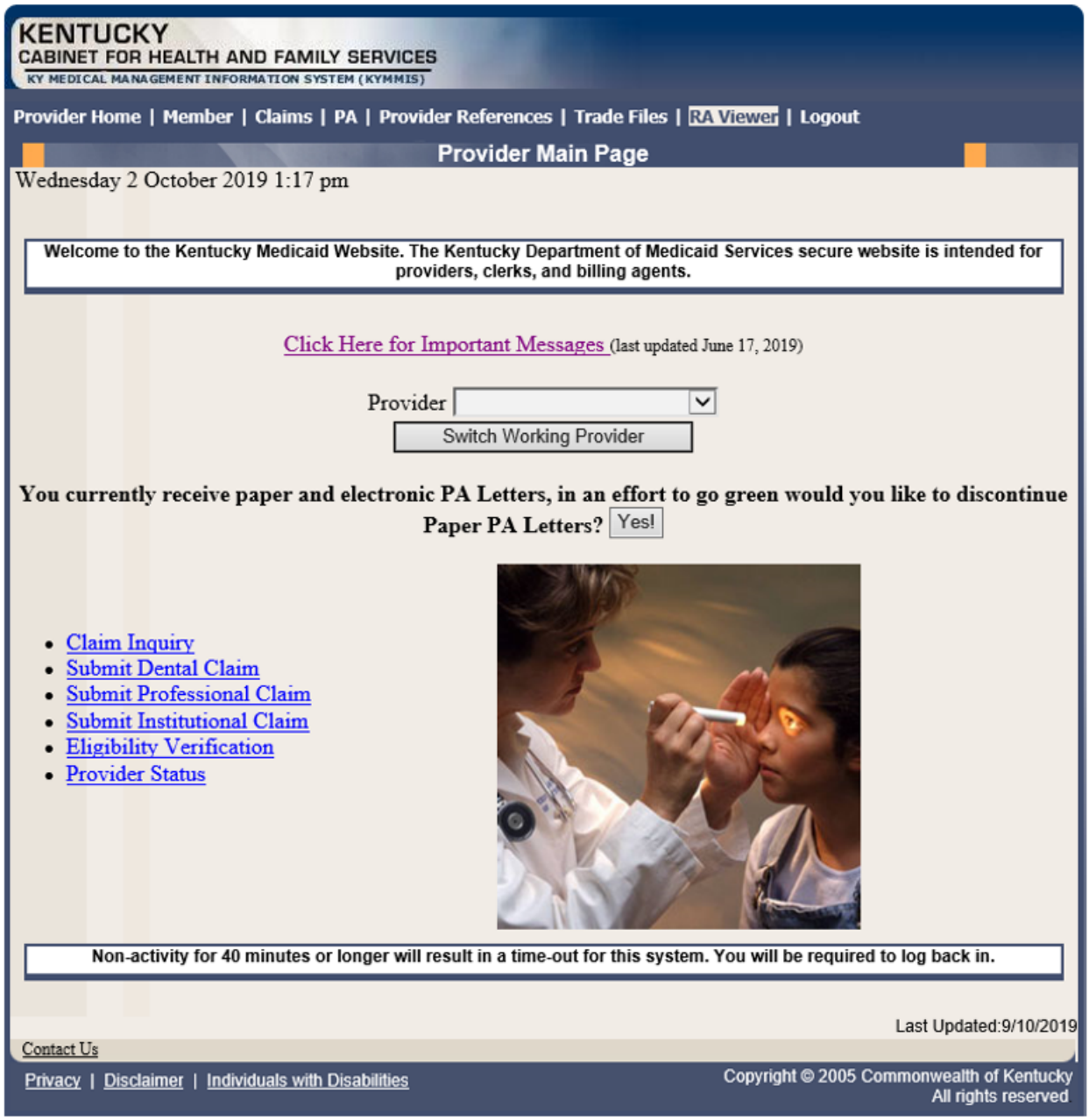


The following screen will appear.

Selected documentation for additional provider resources are available at www.kymmis.com.

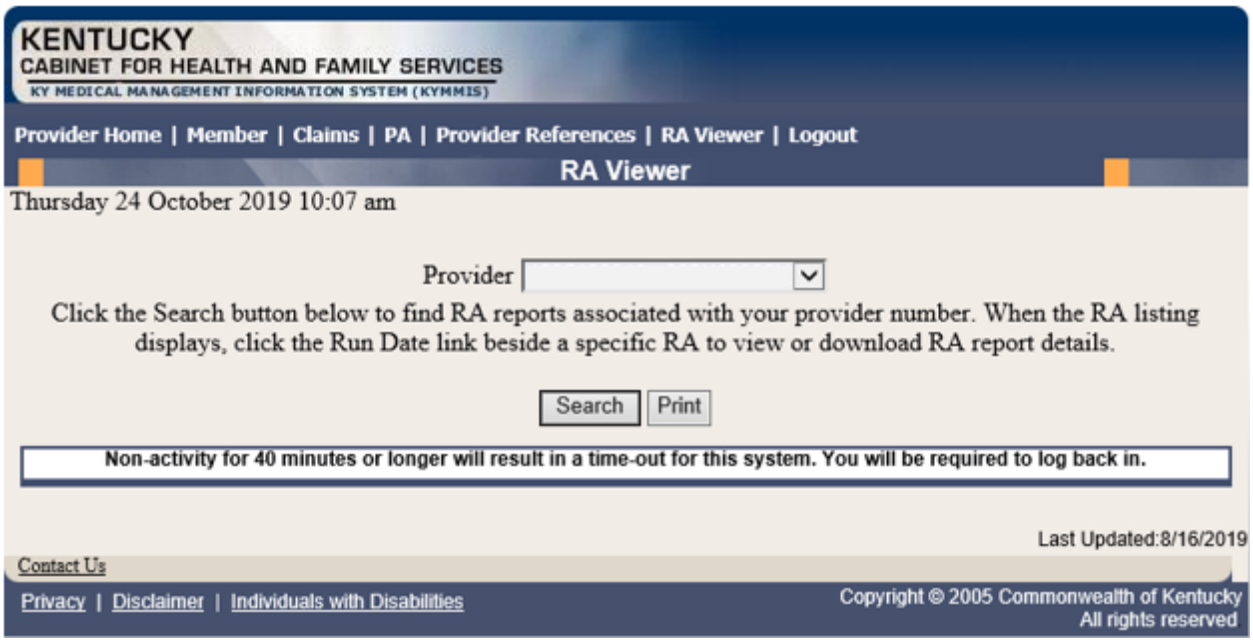
9 RA Viewer

1. Click **RA Viewer** from the menu.



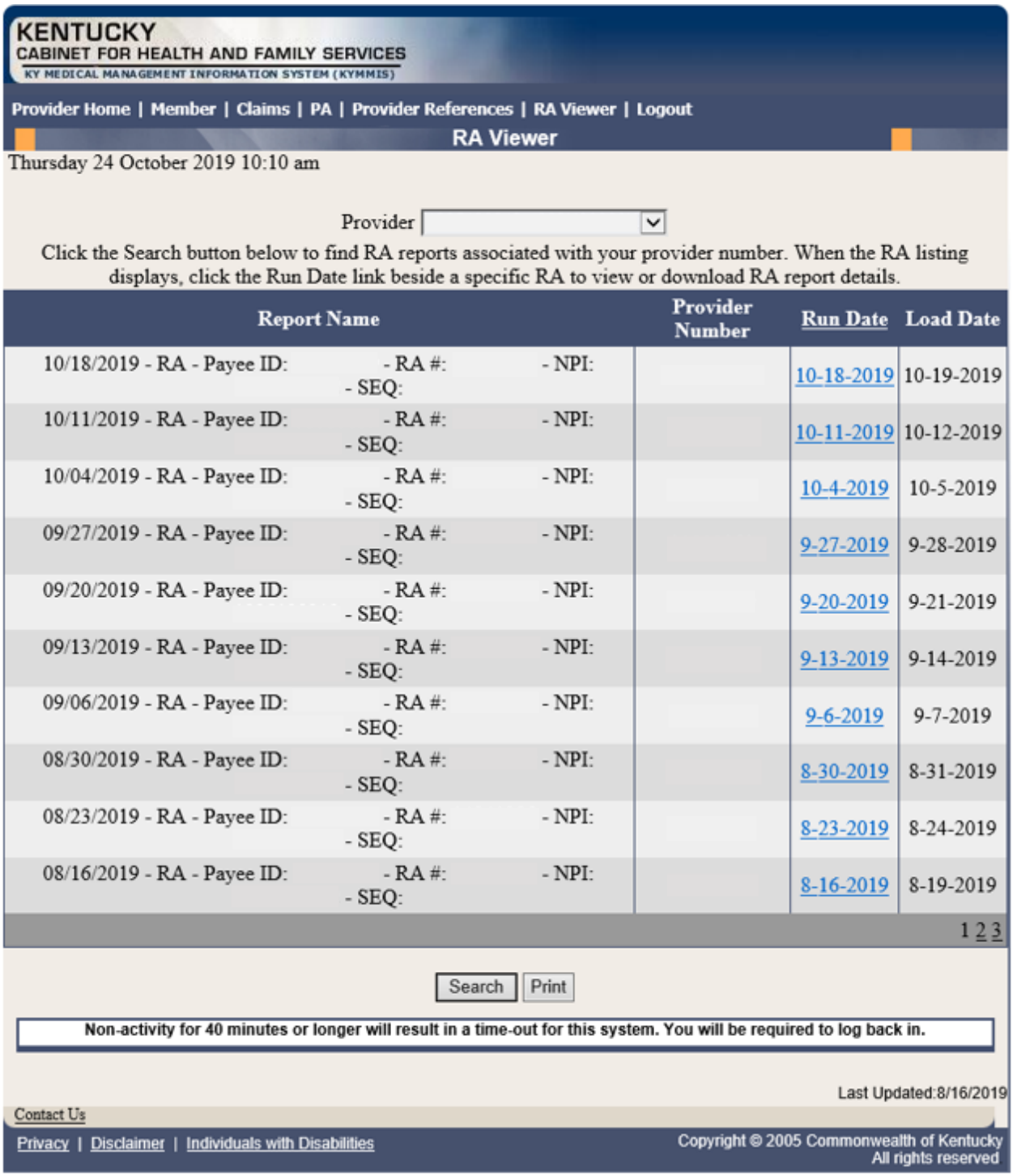
The following screen will appear.

2. Select the provider NPI/Taxonomy from the drop-down menu (if the user works on behalf of multiple providers)
3. Click **Search**.



RA Viewer holds six months of Remittance Advice statements, displaying the most current at the top of the screen. Each RA can be viewed or downloaded.

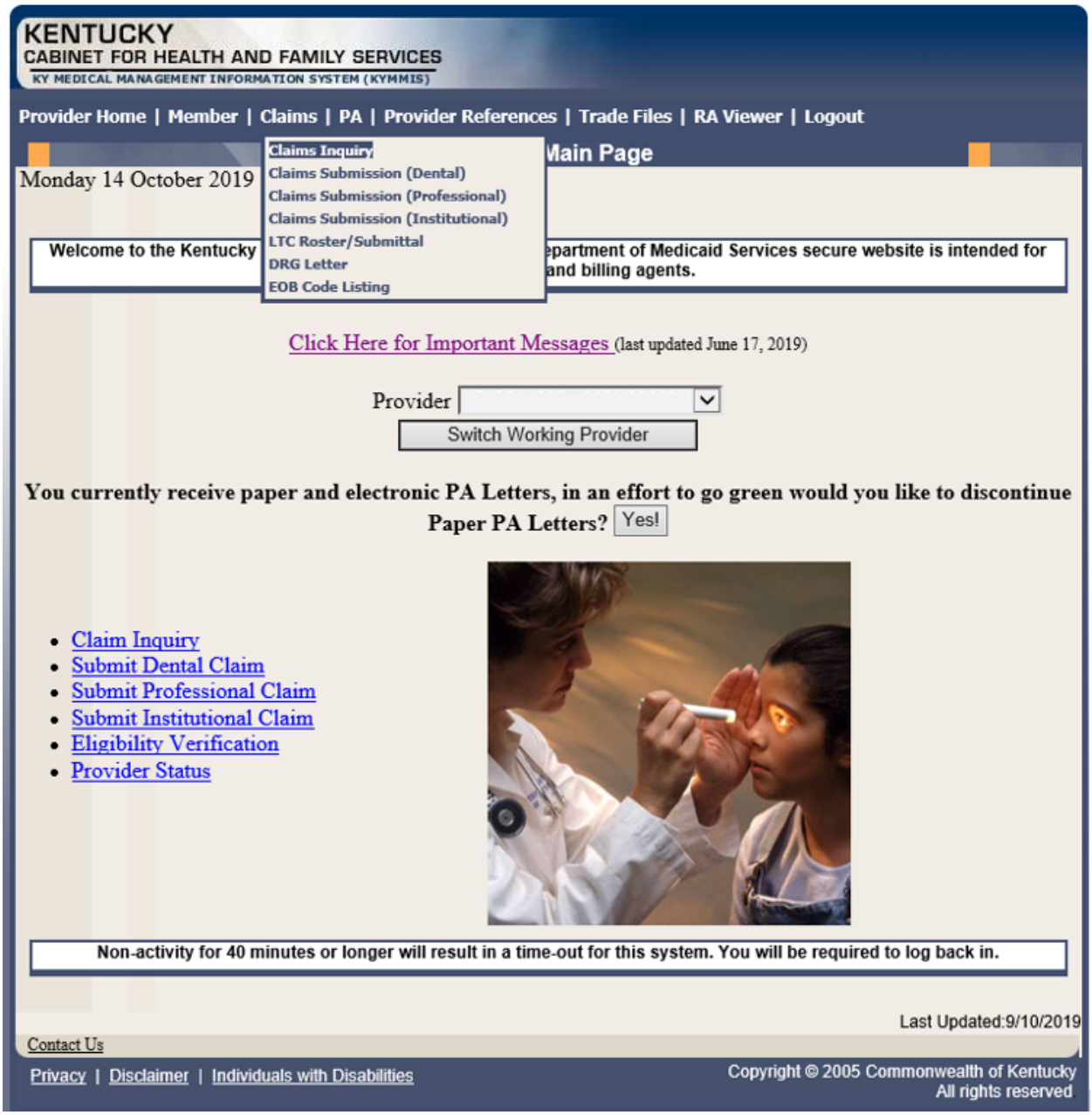
4. Select the applicable Run Date.

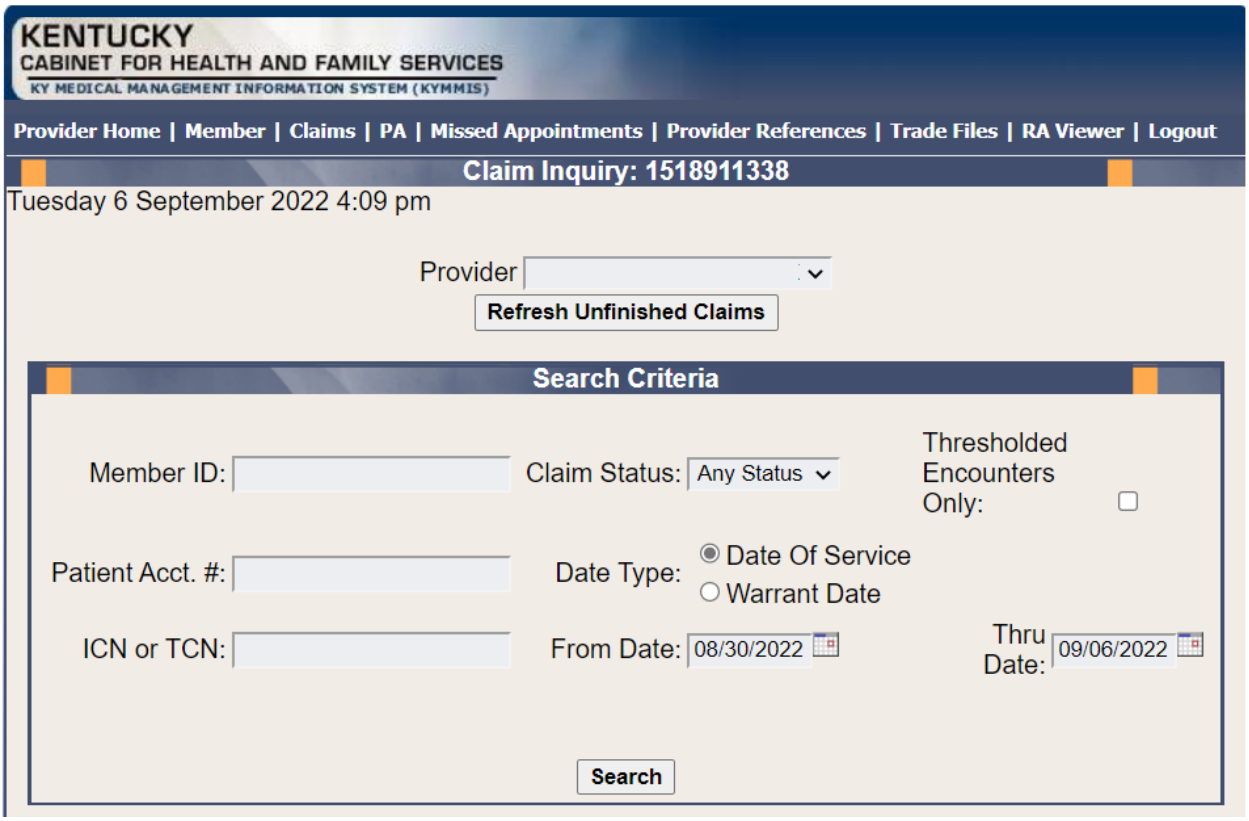


10 Claims

10.1 Claim Inquiry

1. Select **Claims** from the menu.
2. Choose **Claims Inquiry** from the drop-down.



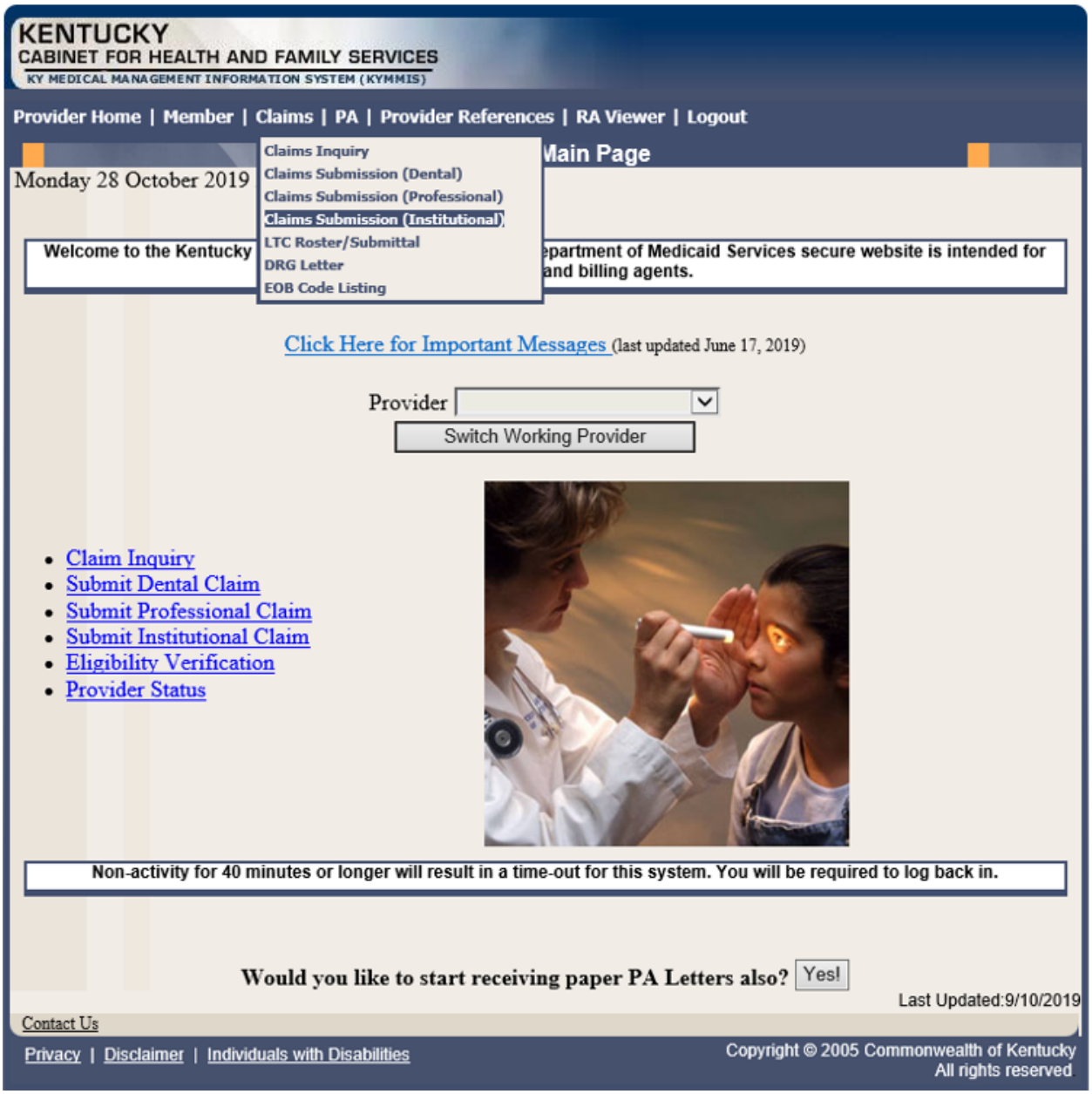


3. Select the applicable NPI and Taxonomy if using an agent or billing agent account.

Enter Member ID and From Date/Thru Date or Patient Acct #	
Claim Status	Any Status, Paid, Denied, and Suspended.
Warrant Date	Warrant Date should read as RA date.
ICN	Enter the ICN and remove From Date/Thru Date.
Date of Service	A search for claim using the dates of service entered.
Unfinished claims	A claim not completed, but saved for future submission.
Thresholded Encounters Only	Search for a Thresholded Encounters. Report is only accessible to PT 31,35,16

10.2 Submitting an Institutional Claim

1. Select **Claims** from the menu.
2. Choose **Claims Submission (Institutional)** from the drop-down.

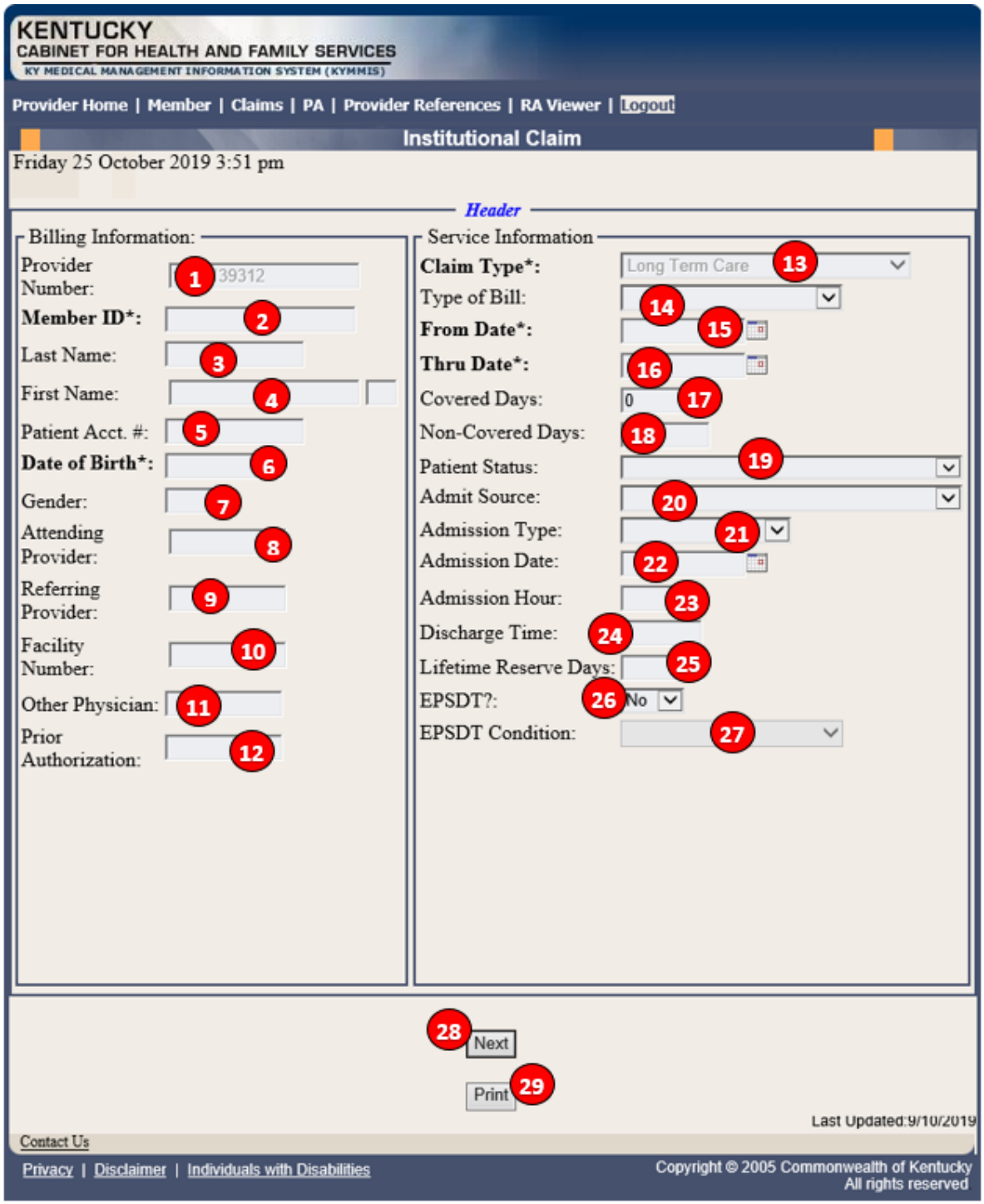


10.2.1 Institutional Claim Header

The claim "Header" information appears on this screen, divided in two columns. The column on the left is the Billing Information and the section on the right contains the Service Information.

Please follow the Provider type Billing Instructions for detailed field-by-field instructions.

Appendix A includes a website link for all Medicaid Billing Instructions.



Institutional Claim Header Screen Descriptions

Field Number / Menu Selection	Definition of Field Description
Billing Information Section	
1	**Provider Number** NPI Number of billing provider (auto-populated).
2	**Member ID** Enter the 10-digit Member's KY MEDICAID ID number.
3	**Last Name** The member's last name (auto-populated).
4	**First Name** The member's first name (auto-populated).
5	**Patient Account Number** Patient's account number (optional).
6	**Date of Birth** The member's date of birth. This field is auto-populated after the member number is entered.
7	**Gender** The member's gender (auto-populated).
8	**Attending Provider** Enter the attending provider's NPI number if applicable.
9	**Referring Provider** Enter the referring provider NPI number.
10	**Facility Number** Enter Billing NIP number.
11	**Other Physician** Enter the other treating physician's NPI number.
12	**Prior Authorization** Enter the Prior Authorization number or Treatment Authorization Number if applicable.
Service Information Section	
13	**Claim Type** Select the appropriate claim type from the drop down box.

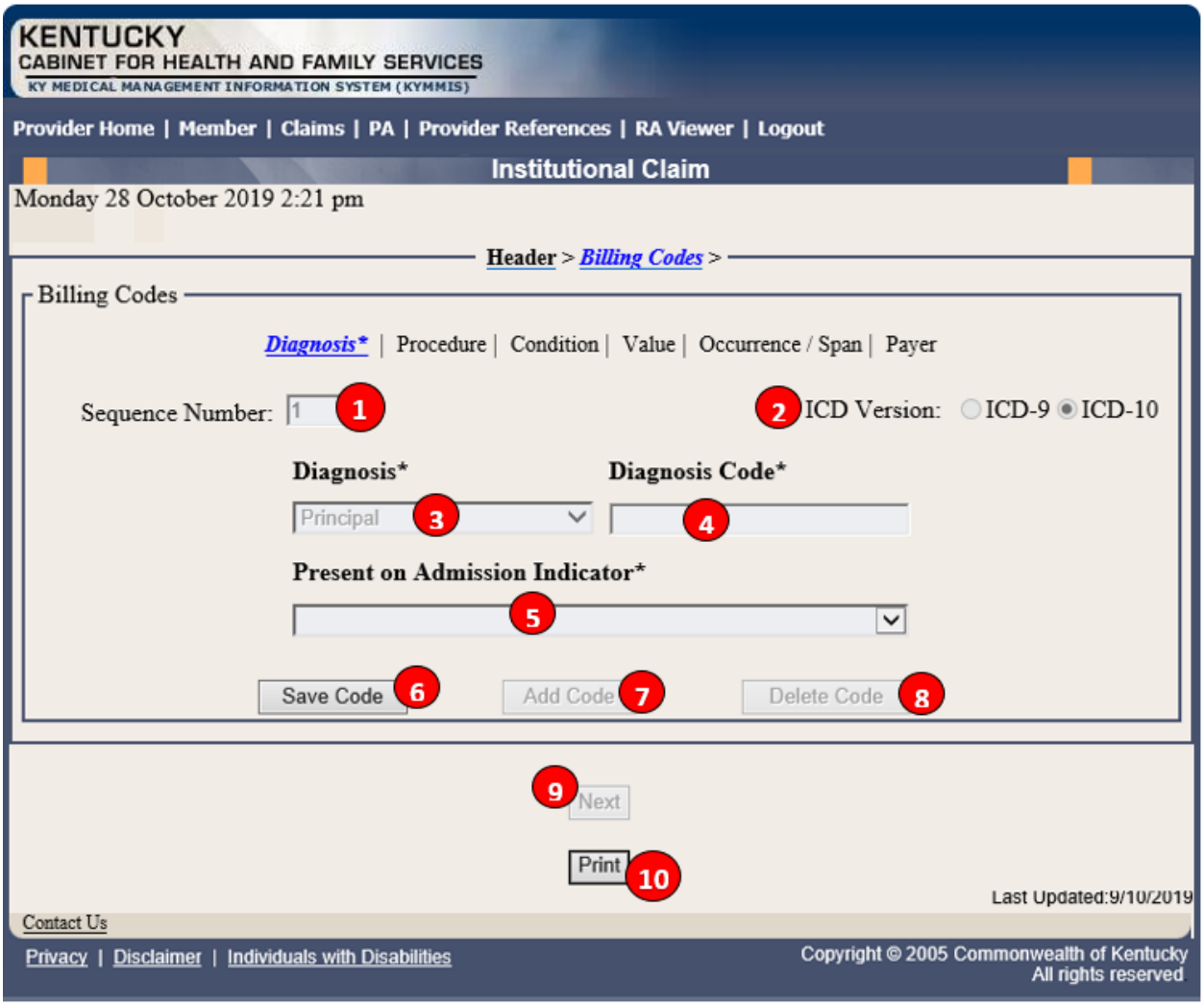
Field Number / Menu Selection	Definition of Field Description
14	**Type of Bill** Select the applicable type of bill.
15	**From Date** Enter the first date of service.
16	**Thru Date** Enter the through date of service.
17	**Covered Days** Enter the number of days billed on the claim.
18	**Non-Covered Days** Enter the number of non-covered days billed on the claim.
19	**Patient Status** Enter the patient's status on "through" date.
20	**Admit Source** Select the admission source.
21	**Admission Type** Select the admission type.
22	**Admission Date** Enter the patient's date of admission to the facility.
23	**Admission Hour** Enter the patient's hour of admission.
24	**Discharge Time** Enter the time of patient's discharge.
25	**Lifetime Reserve Days** Number of lifetime reserve days (Medicare only).
26	**EPSDT** Indicates an EPSDT related service (if applicable).
27	**EPSDT Condition** Indicate the appropriate condition from the drop-down.
28	**Next** Advance to the diagnosis screen.
29	**Print** Allows the user to print this screen.

10.2.2 Billing Code Screens

This portion includes separate screens accessed by clicking the appropriate links: **Diagnosis**, **Procedure**, **Condition**, **Value**, **Occurrence/Span**, and **Payer**. Be sure to click the **Save Code** button after entering the information on each screen.

Field-by-field instructions follow.

10.2.2.1 Billing Codes – Diagnosis



Present on Admission (POA) Indicator

Claim Type	Requirement
Inpatient Claim	The **POA** field is displayed for all but Admitting and Emergency diagnosis code fields.
Inpatient crossover claim/TOB 111-114 and 121-124	The POA field is displayed for all diagnosis codes except Admitting and Emergency.
Outpatient Claims	No POA required.

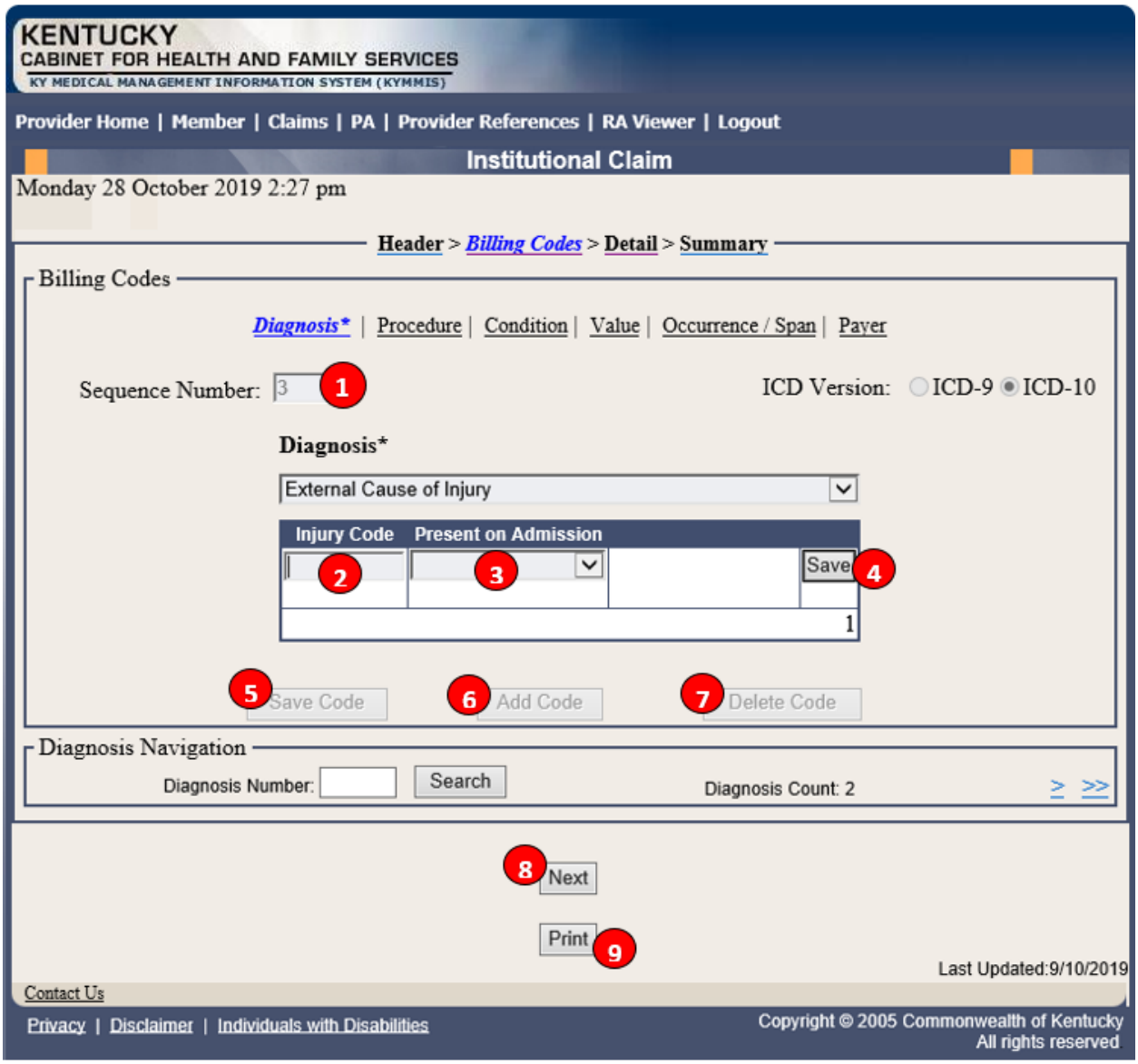
POA Indicator values

3. Blank/space
4. Yes (Y)
5. No (N)
6. Unknown (U)
7. Clinically Undetermined (W)

*The **POA** field is not available for Admitting Diagnosis and Emergency Diagnosis.

Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the diagnosis. This field is auto-populated.
2	**ICD Version – Feature available with ICD-10 implementation** Select the appropriate ICD version.
3	**Diagnosis (drop-down)** Select the type of diagnosis, i.e., Principle, Admitting.
4	**Diagnosis Code** Enter the appropriate code for the member's diagnosis. (Do not enter a decimal in Diagnosis Code.)
5	**POA** Choose the appropriate POA indicator.
6	**Save Code** Saves the diagnosis information on the claim. A save is required to continue.
7	**Add Code** Allows the user to add an additional diagnosis code to the claim. Save the code after each additional code is added.
8	**Delete Code** Allows the user to remove a diagnosis code previously entered on the claim.
9	**Next** Advance to the next screen.
10	**Print** Allows the user to print this screen.

10.2.2.2 Billing Codes – External Cause of Injury



Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the procedure codes. This field is auto-populated.
2	**Injury Code** Enter the appropriate code for the member's injury.
3	**Present on Admission** Choose the appropriate POA indicator.

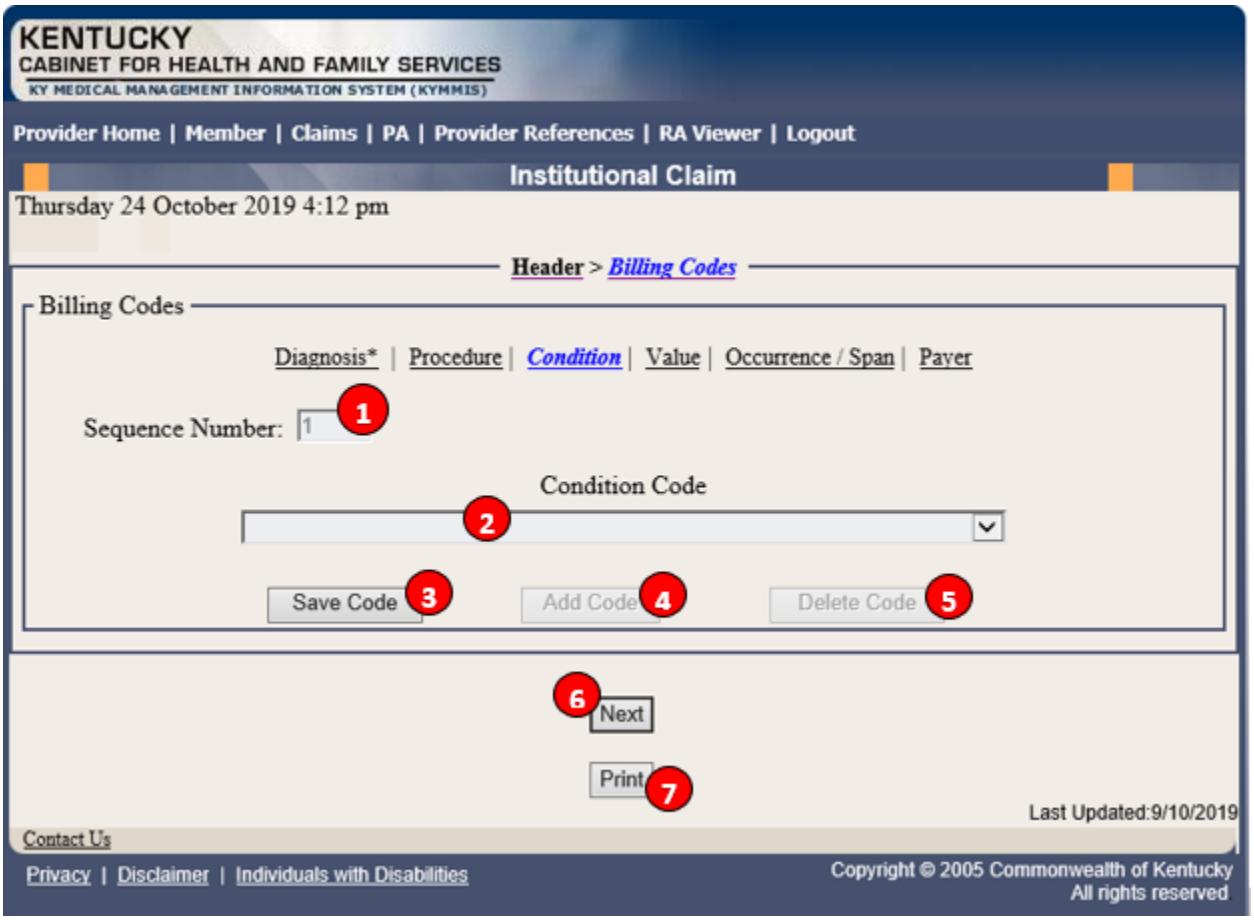
Field Number / Menu Selection	Definition of Field Description
4	**Save** Saves the Present on Admission code on the claim. A save is required to continue.
5	**Save Code** Saves the procedure information on the claim. A save is required code to continue.
6	**Add Code** Allows the user to add an additional procedure code to the claim. Save the code after each additional code is entered.
7	**Delete Code** Allows the user to remove a procedure code previously entered on the claim.
8	**Next** Advance to the next screen.
9	**Print** Allows the user to print this screen.

10.2.2.3 Billing Codes – Procedure

Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the procedure codes. This field is auto-populated.
2	**ICD Version – Feature available with ICD-10 implementation** Select the appropriate ICD version.
3	**Procedure Code** Enter the ICD-CM procedure code.
4	**Date** Enter the DOS that the procedure was done.
5	**Save Code** Saves the procedure information on the claim. A save is required to continue.

Field Number / Menu Selection	Definition of Field Description
6	**Add Code** Allows the user to add an additional procedure code to the claim. Save the code after each additional code is added.
7	**Delete Code** Allows the user to remove a procedure code previously entered on the claim.
8	**Next** Advance to the next screen.
9	**Print** Allows the user to print this screen.

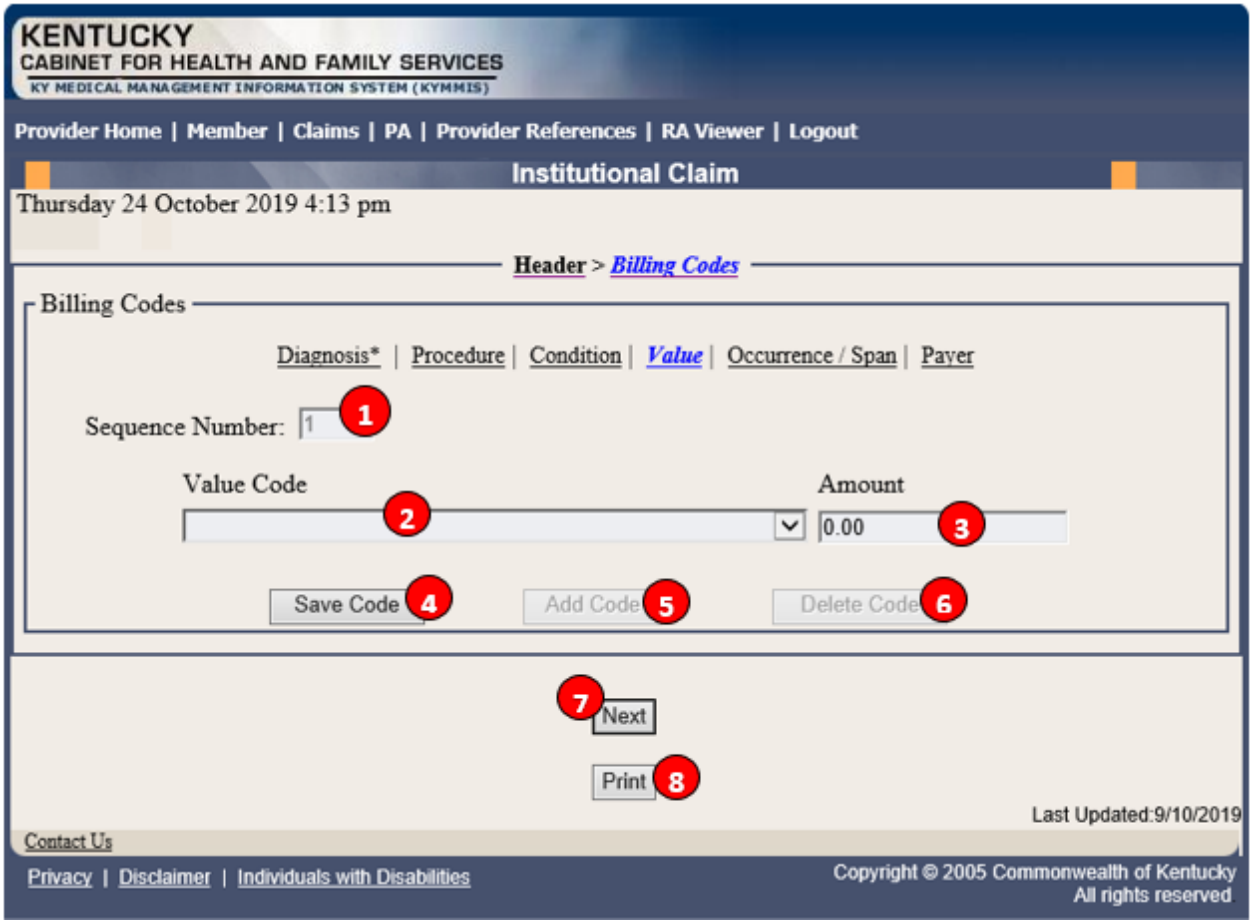
10.2.2.4 Billing Codes – Condition



Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the diagnosis. This field is auto-populated.
2	**Condition Code (drop-down)** Select the appropriate condition. Home Health agencies will use the first Payer Codes option when a MAP 34 is on file. This option is coded to the HIPAA qualifier of 12, which is the equivalent to the old Y1 indicator.
3	**Save Code** Saves the condition information on the claim. A save is required to continue.
4	**Add Code** Allows the user to add an additional condition code to the claim. Save the code after each additional code is added.

Field Number / Menu Selection	Definition of Field Description
5	**Delete Code** Allows the user to remove a condition code previously entered on the claim.
6	**Next** Advance to the next screen.
7	**Print** Allows the user to print this screen.

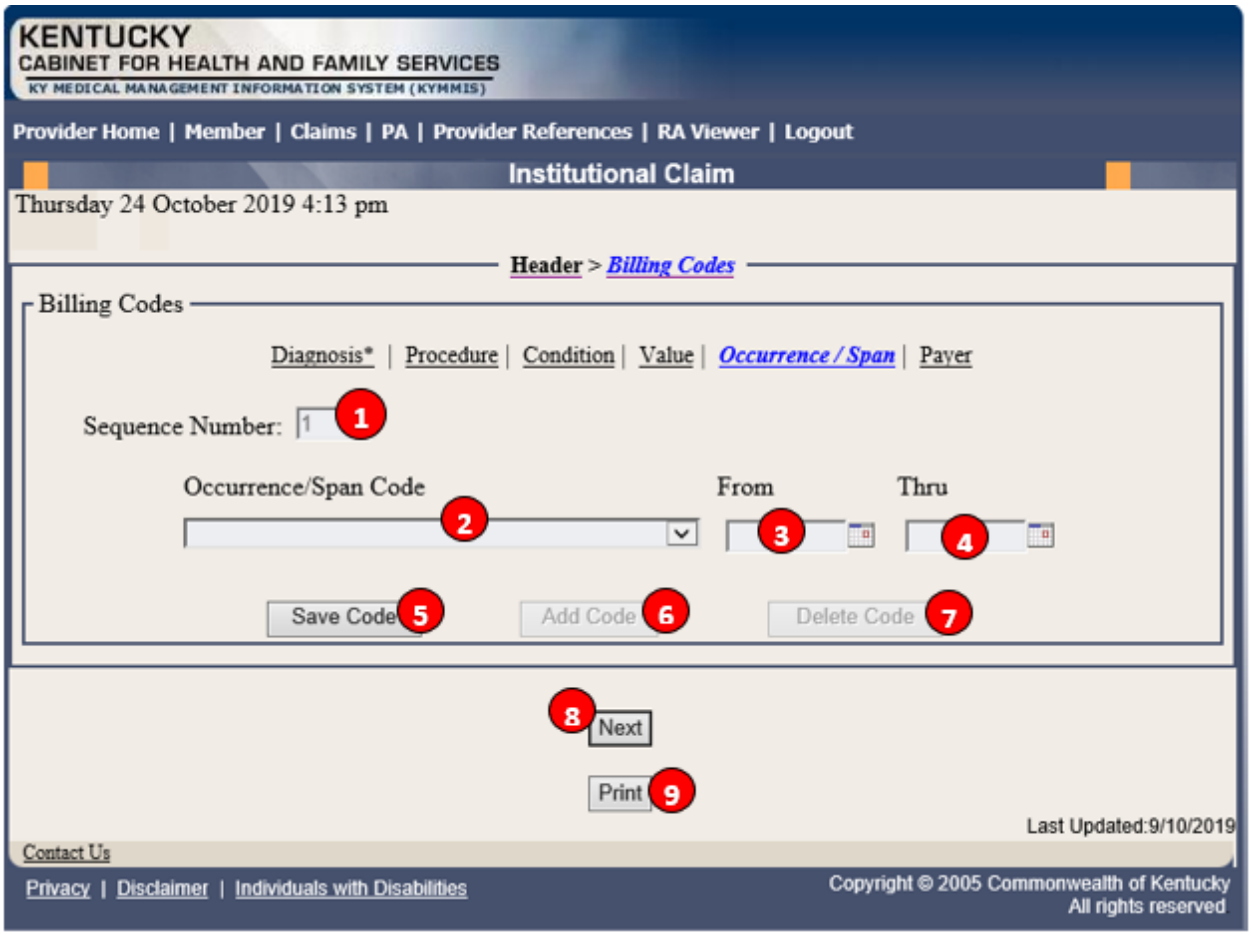
10.2.2.5 Billing Codes – Value



Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the diagnosis. This field is auto-populated.
2	**Value Code (drop-down)** Select the appropriate value code.
3	**Amount** Enter the corresponding dollar amount.
4	**Save Code** Saves the value code information on the claim. A save is required to continue.
5	**Add Code** Allows the user to add an additional value code to the claim. Save the code after each additional code is added.

Field Number / Menu Selection	Definition of Field Description
6	**Delete Code** Allows the user to remove a value code previously entered on the claim.
7	**Next** Advance to the next screen.
8	**Print** Allows the user to print this screen.

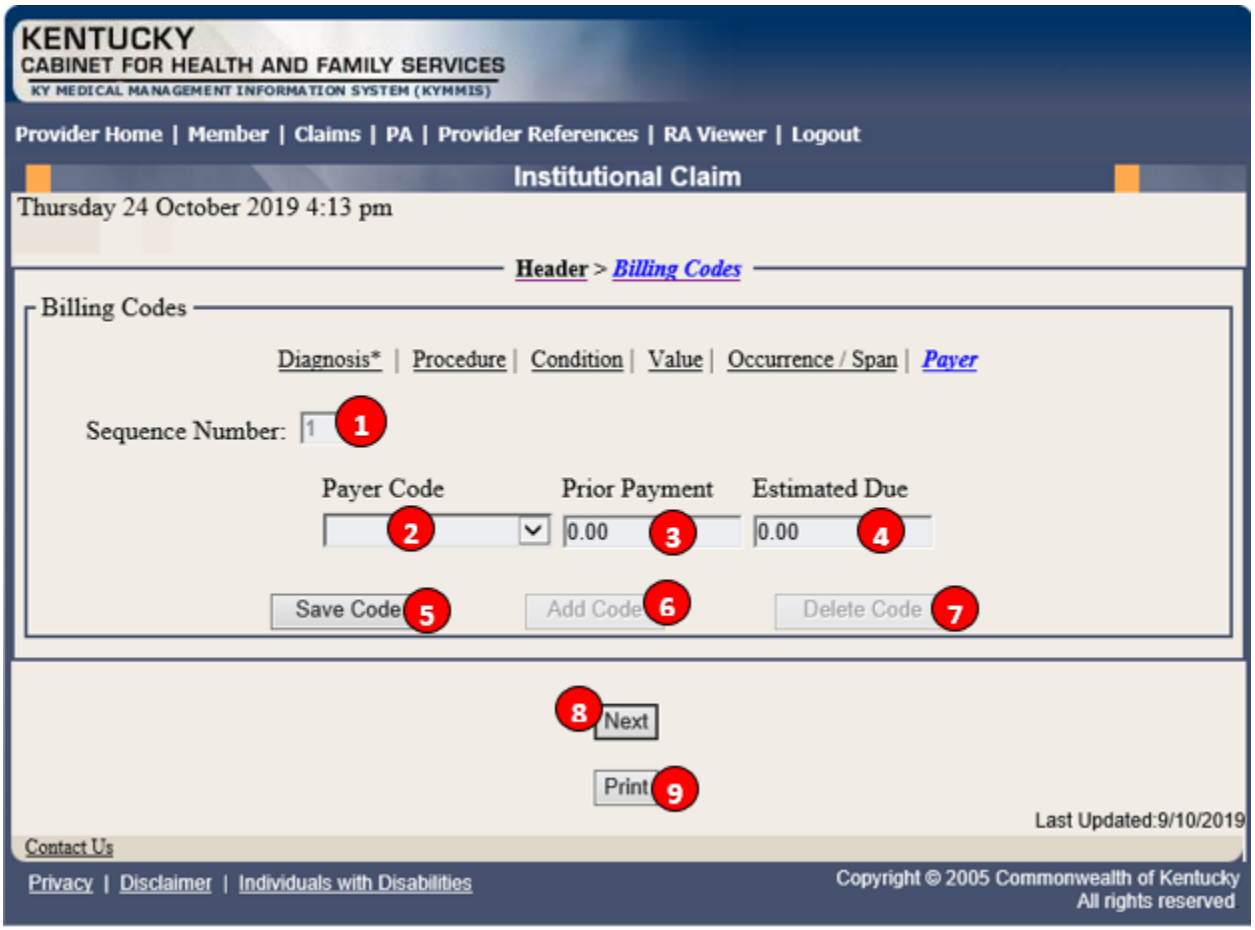
10.2.2.6 Billing Codes – Occurrence/Span



Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the occurrence. This field is auto-populated.
2	**Occurrence/Span Code (drop-down)** Select the appropriate code.
3	**From** Enter the corresponding **From** date.
4	**Thru** Enter the corresponding **Through** date.
5	**Save Code** Saves the occurrence code information on the claim. A save is required to continue.

Field Number / Menu Selection	Definition of Field Description
6	**Add Code** Allows the user to add an additional occurrence code to the claim. Save the code after each additional code is added.
7	**Delete Code** Allows the user to remove an occurrence code previously entered on the claim.
8	**Next** Advance to the next screen.
9	**Print** Allows the user to print this screen.

10.2.2.7 Billing Codes – Payer



Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the Payer. This field is auto-populated.
2	**Payer Code (drop-down)** Select the appropriate code: Medicare, TPL, or Medicaid.
3	**Prior Payment** TPL private insurance payment (not Medicaid, not Medicare).
4	**Estimated Due** Enter the estimated amount due.
5	**Save Code** Saves the payer code information on the claim.
6	**Add Code** Allows the user to add an additional payer code to the claim.

Field Number / Menu Selection	Definition of Field Description
7	**Delete Code** Allows the user to remove a payer code previously entered on the claim.
8	**Next** Advance to the next screen.
9	**Print** Allows the user to print this screen.

10.2.3 Detail Screen

Field Number / Menu Selection	Definition of Field Description
1	**Item** Line number of the detail. This field is auto-populated.
2	**From DOS*** Enter the first date the services were provided. The * indicates that this field is required.

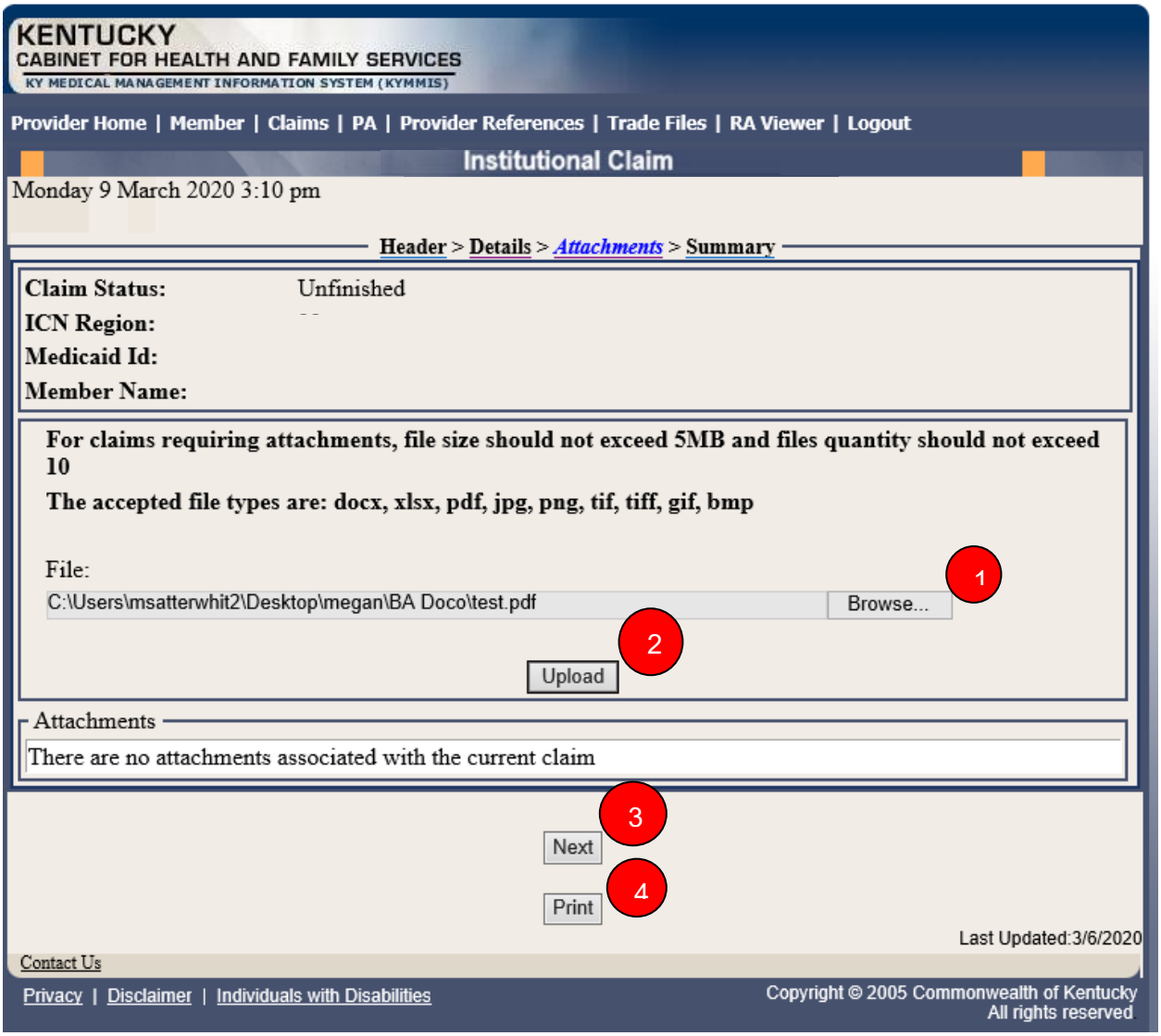
Field Number / Menu Selection	Definition of Field Description
3	**To DOS*** Enter the last date the services were provided. The * indicates that this field is required.
4	**Revenue Code** Enter the four-digit revenue code which identifies the service provided (the first digit will be a zero).
5	**HCPCS/Rates** Enter the procedure code which further identifies the service provided. This field is for all out patient claims.
6	**Modifiers** Enter the appropriate two-digit modifier(s) which further describes the service performed.
7	**Units** Enter the number of units.
8	**Units of Measurement** Enter units of measurement, i.e., days.
9	**Charges** The amount charged by the provider.
10	**Co-pay** The co-payment deducted from reimbursement. No information should be entered into this field.
11	**TPL Amount** Enter the amount paid by other insurance.
12	**Referring Provider** Enter the Referring Provider number.
13	**Status** The status of the claim.
14	**Allowed Amount** The amount allowed by Kentucky Medicaid (paid claims only).
15	**Non Covered Charges** The amount of charges not covered by Kentucky Medicaid.
16	**Units Allowed** The number of units allowed.

Field Number / Menu Selection	Definition of Field Description
17	**Paid Amount** The amount paid by Kentucky Medicaid.
18	**Add NDC** Enter the 11-digit NDC code. This is currently only used by hospitals for outpatient services.
19	**Save Detail** This button saves the detail line on the claim.
20	**Add Detail** This button allows the user to add an additional detail line.
21	**Delete Detail** This button allows the user to remove the detail line previously entered.
22	**Next** Click **Next** to continue to the **Attachments** screen.
23	**Print** Allows the user to print this screen.

10.2.4 Attachments Screen

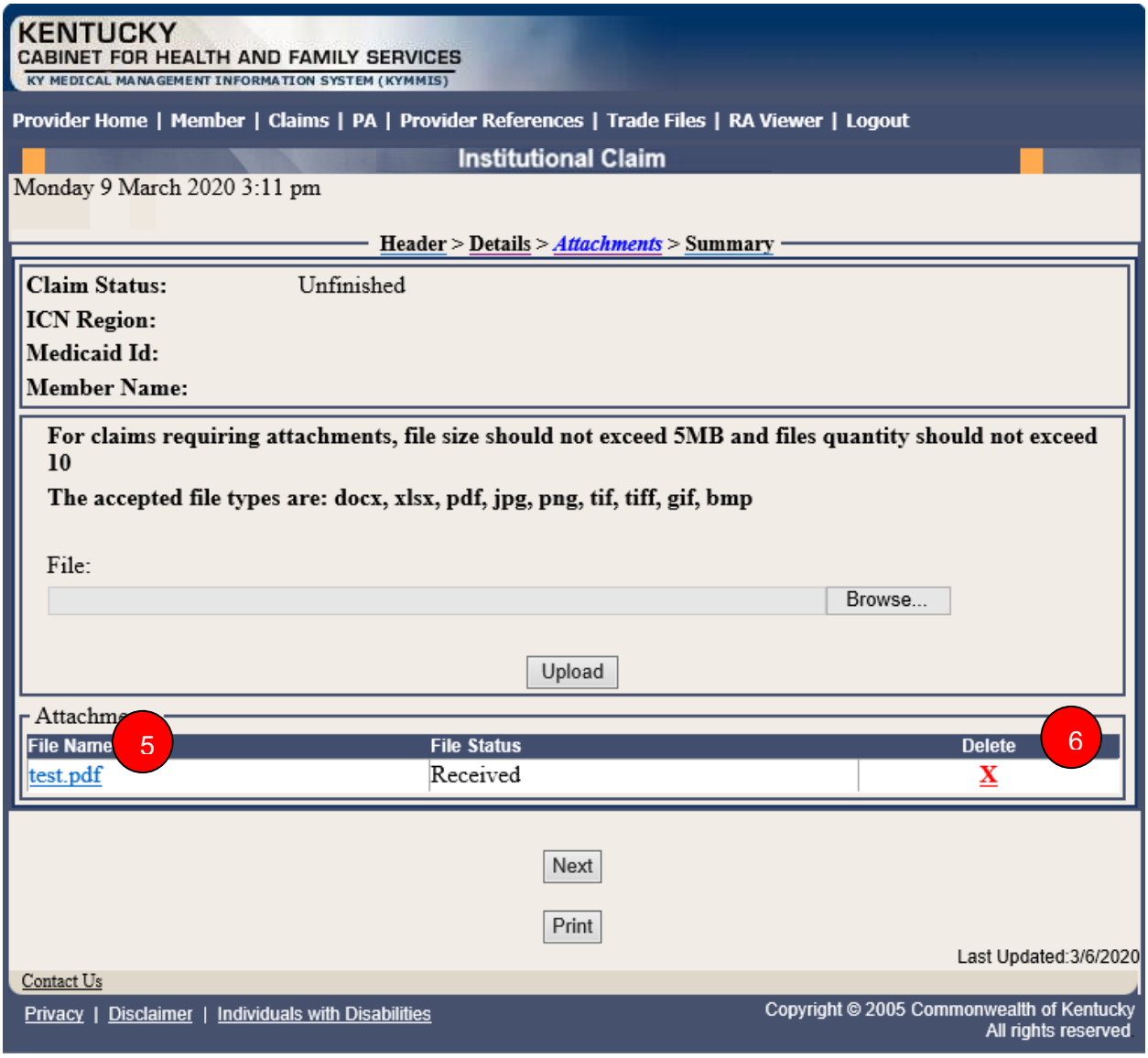
Below are instructions for utilizing screen functionality.

1. Select **Browse** to find the file to attach.
2. Select **Upload** to attach file to claim.



Attachments Screen Continued:

Screen displays after upload is selected



Attachment Screen Field Descriptions

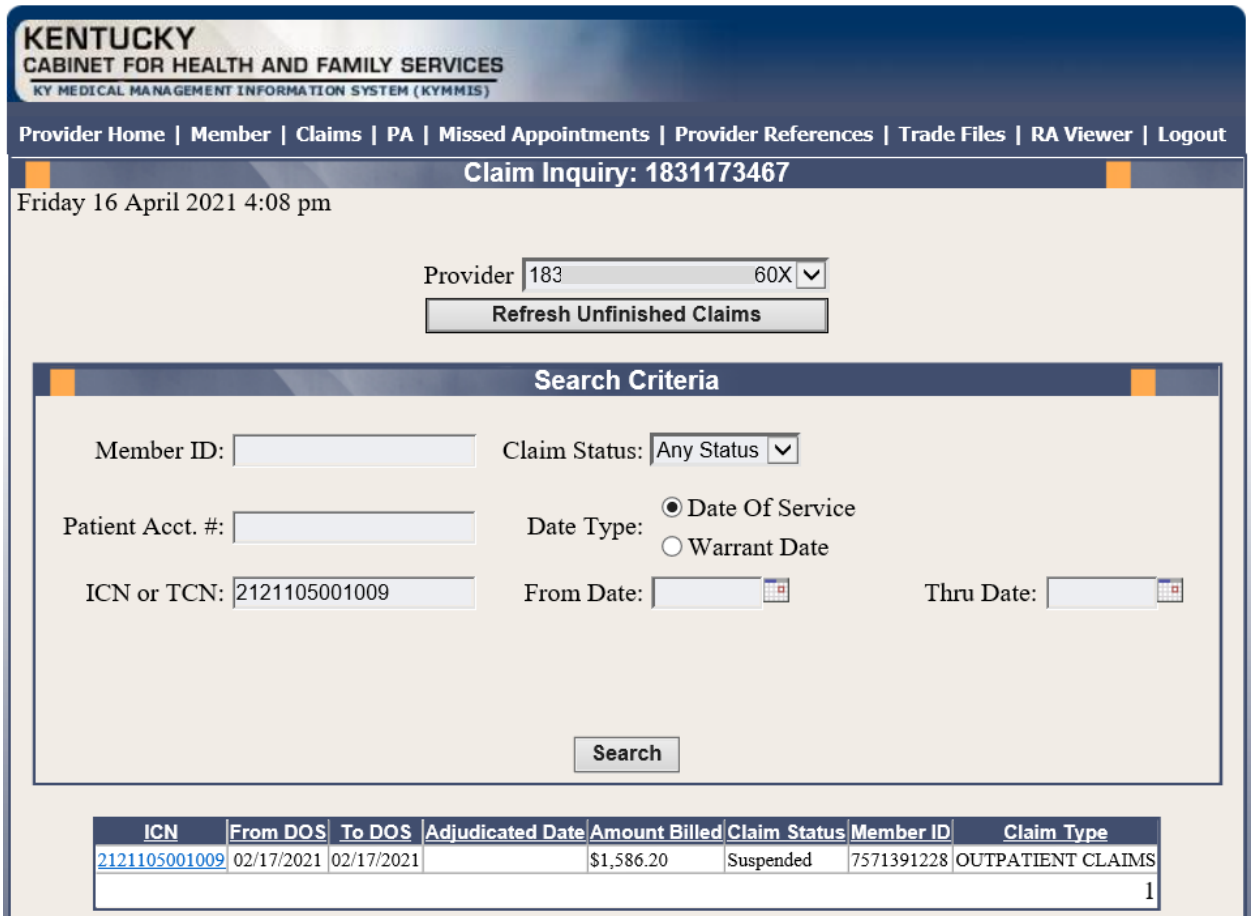
Field Description	Definition of Field Description
1	**Browse** Allows the user to search for file.
2	**Upload** Allows the user to attach a file to the claim.
3	**Next** Click **Next** to continue to the **Summary** screen.
4	**Print** Allows the user to print this screen.
5	**Attachments Link** Allow user to view attachment
6	**Remove** Allows user to remove attachment

10.2.5 EDI Claim Attachments

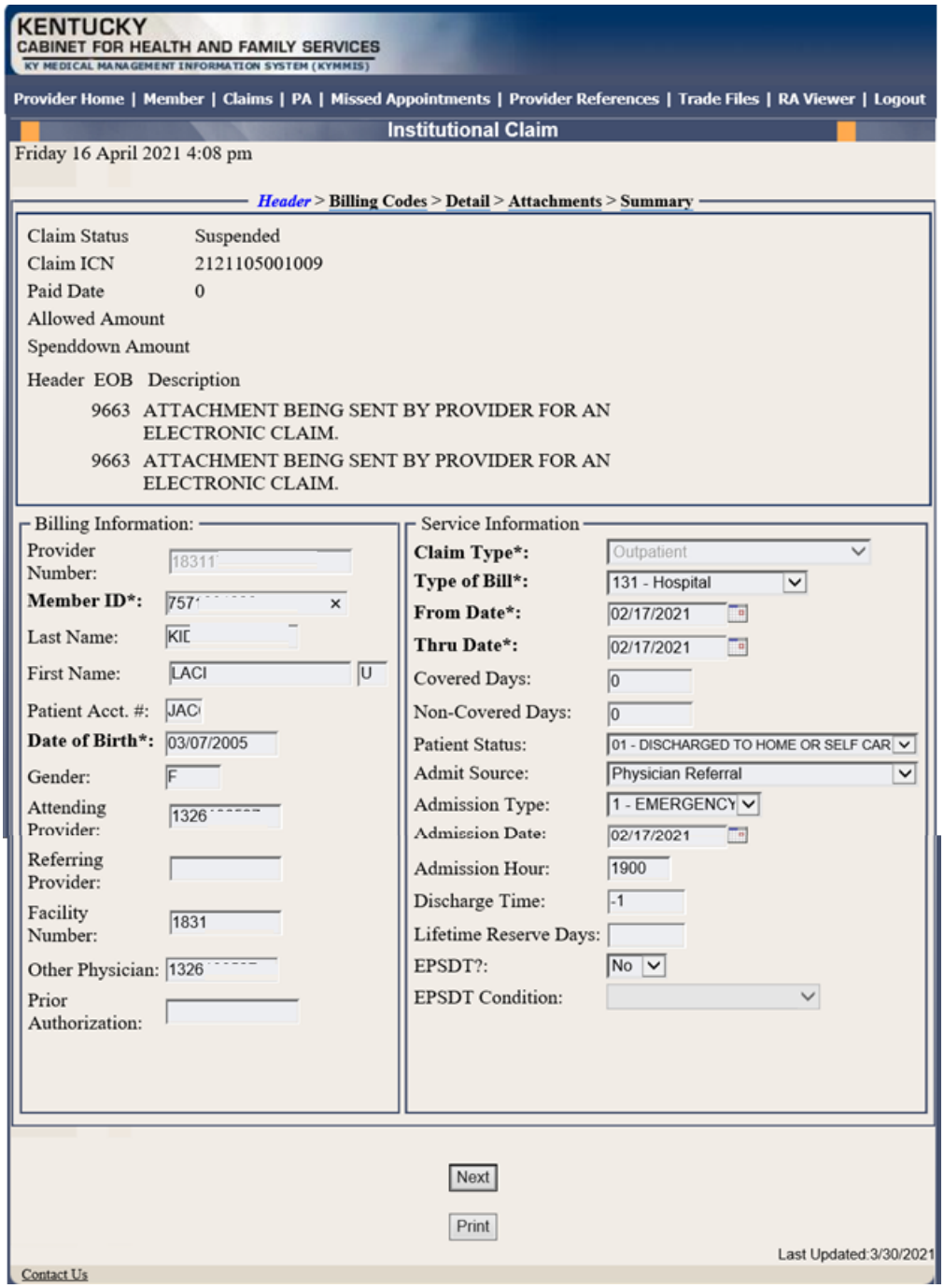
When an EDI claim comes in with an 'FT' transmission code in the PWK segment, KYHealthNet will recognize this as an EDI claim with attachment(s) and allow the user to finalize the claim by uploading the respective attachment(s).

- These are EDI claims, and per X12 guidelines there can be **header** and **detail** attachments.
- There is a limit of 10 attachments at the header level and 10 attachments at the detail level.
- If an EDI claim has more than 10 header or detail 'FT' PWK segments, KYHealthNet will only recognize the first 10 (per header and detail).
- The ICN region for EDI claims with attachments is '21'.
- If a user submits 5 PWK segments with 'FT' on the EDI claim, then they will have to upload 5 attachments on KYHealthNet for this claim, in order to be able to finalize it.
- Adjustments will work the same as KYHealthNet claims with attachments (cannot adjust a PAID '23' or '21' ICN)
- If a user goes in to resubmit a denied '21' ICN, the attachments will follow the KYHealthNet claim attachments guidelines (since they will be resubmitting, it will change the ICN to a region '23' – KYHealthNet claim with attachments and will no longer be an EDI claim)

Search Claim



View Header

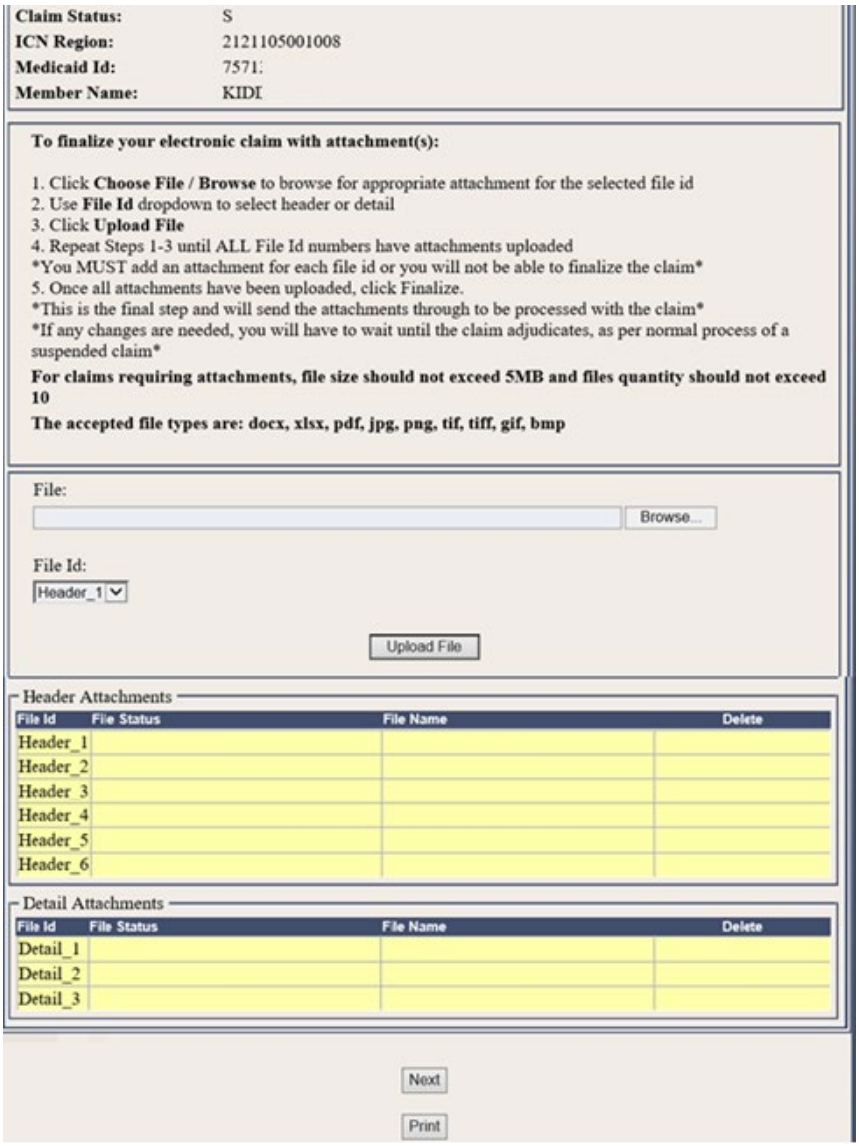

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
KY MEDICAL MANAGEMENT INFORMATION SYSTEM (KYMMIS)
Provider Home | Member | Claims | PA | Missed Appointments | Provider References | Trade Files | RA Viewer | Logout
Institutional Claim
Friday 16 April 2021 4:08 pm
Header > Billing Codes > Detail > Attachments > Summary
Claim Status Suspended
Claim ICN 2121105001009
Paid Date 0
Allowed Amount
Spenddown Amount
Header EOB Description
9663 ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.
9663 ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.
Billing Information:
Provider Number: 18311
Member ID*: 757
Last Name: KIE
First Name: LACI U
Patient Acct. #: JAC
Date of Birth*: 03/07/2005
Gender: F
Attending Provider: 1326
Referring Provider:
Facility Number: 1831
Other Physician: 1326
Prior Authorization:
Service Information
Claim Type*: Outpatient
Type of Bill*: 131 - Hospital
From Date*: 02/17/2021
Thru Date*: 02/17/2021
Covered Days: 0
Non-Covered Days: 0
Patient Status: 01 - DISCHARGED TO HOME OR SELF CAR
Admit Source: Physician Referral
Admission Type: 1 - EMERGENCY
Admission Date: 02/17/2021
Admission Hour: 1900
Discharge Time: -1
Lifetime Reserve Days:
EPSDT?: No
EPSDT Condition:
Next
Print
Last Updated:3/30/2021
Contact Us

Navigate to Attachments Screen

1.Select **Browse** to find the EDI file to attach.

2. Select a **File ID** from the dropdown**.**

3. Select **Upload File** button to attach the EDI file to the claim.



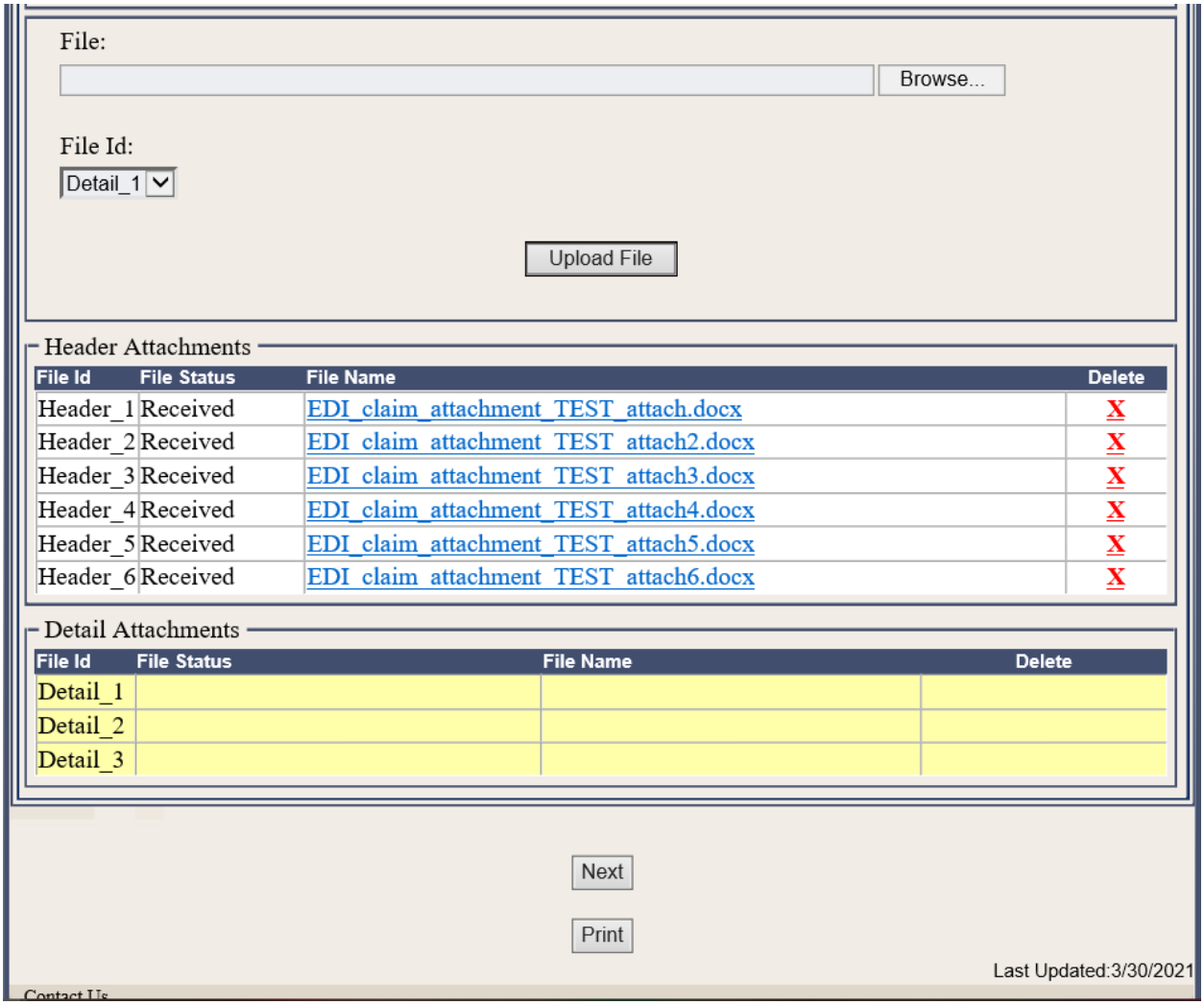
Attachments Screen continued

Detail Attachments

1.Select **Browse** to find the EDI file to attach.

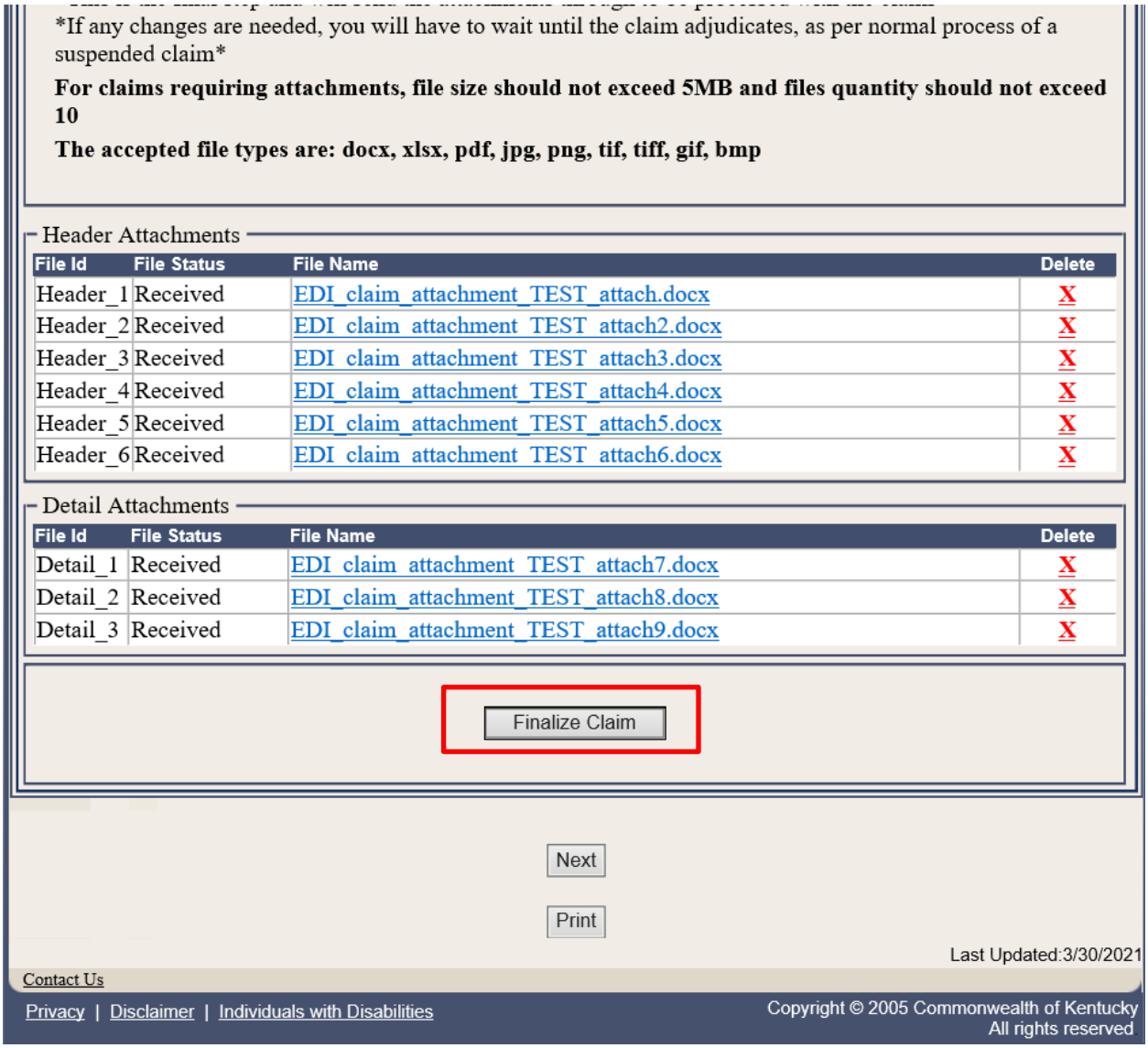
2.Select **File ID** from the dropdown**.**

3. Select **Upload File** button to attach the EDI file to the claim.

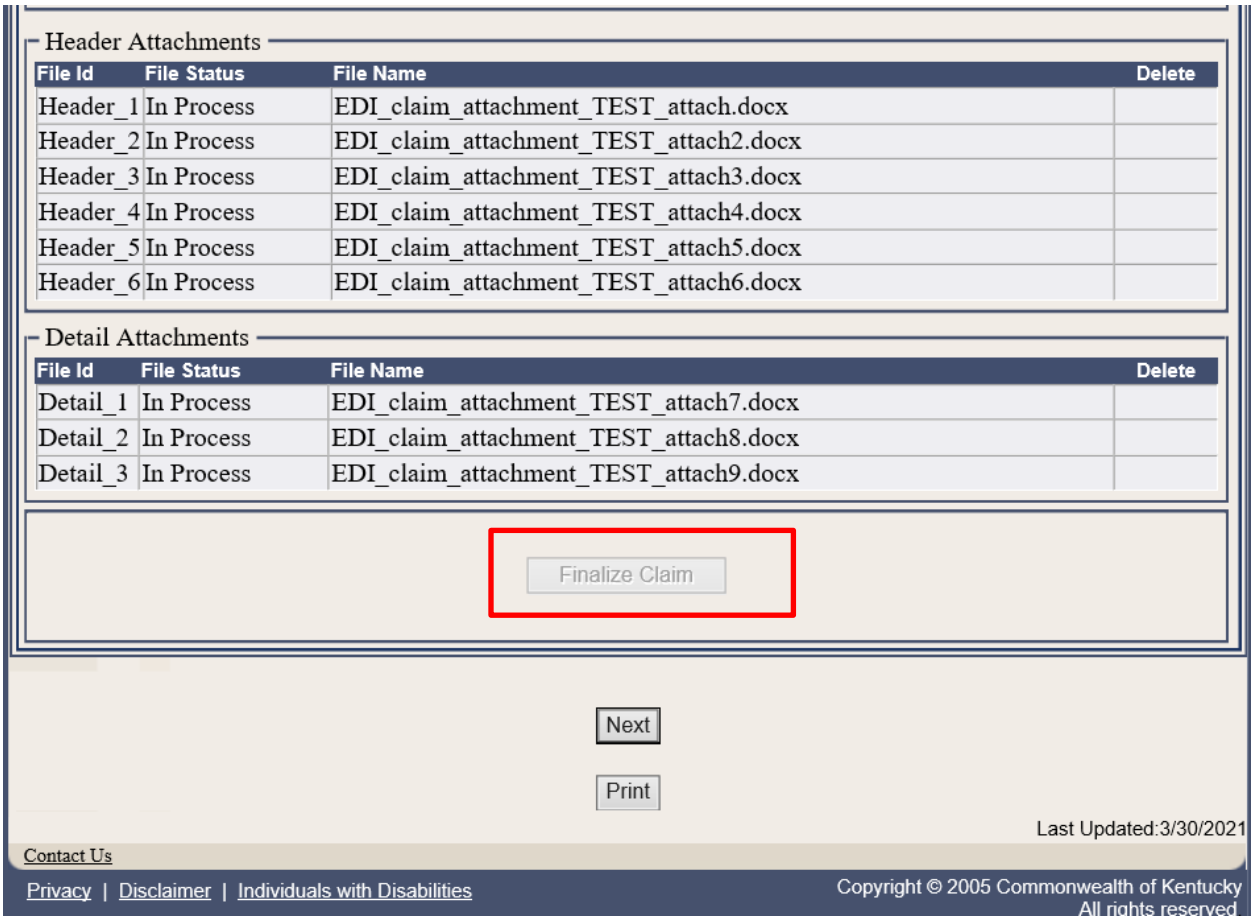


Once all EDI files are uploaded, user selects the Finalize Claim button.

Note: If a file needs to be deleted the user must do so before finalizing the claim.



The claim is now finalized no other updates can be made.



Summary Page

View the finalized claim.

Billing Information

Provider Number	1326
Member ID	7571
Last Name	KID
First Name	LAC_ _
Date of Birth	03/07/2005
Gender	F
Patient Acct. #	0001(
Referring Provider	1326(
Prior Authorization	

Service Facility Location

Service Location ID:
Service Location Name:
Address:
City:
State: Zip Code:

Service Information

From Date	01/21/2021	To Date	01/30/2021
Accident		Accident Date	
EPSDT			

Claim Charges

Total Charges	40.00
TPL Amount	0.00
Total Amount Paid	
Carrier Denied?	
Co-Pay Amount	0.00

Diagnosis Codes

Item	Diagnosis Code (ICD-10)
1	F959
2	G514
3	G5139
4	F840
5	M62838
6	E6601
7	R5382
8	Z79899

Header Attachments

File Id	File Name
1	EDI_claim_attachment_TEST_attach\1.docx
2	EDI_claim_attachment_TEST_attach\2.docx
3	EDI_claim_attachment_TEST_attach\3.docx
4	EDI_claim_attachment_TEST_attach\4.docx
5	EDI_claim_attachment_TEST_attach\5.docx
6	EDI_claim_attachment_TEST_attach\6.docx

Detail Attachments

File Id	File Name
1	EDI_claim_attachment_TEST_attach\7.docx
2	EDI_claim_attachment_TEST_attach\8.docx
3	EDI_claim_attachment_TEST_attach\9.docx

Details

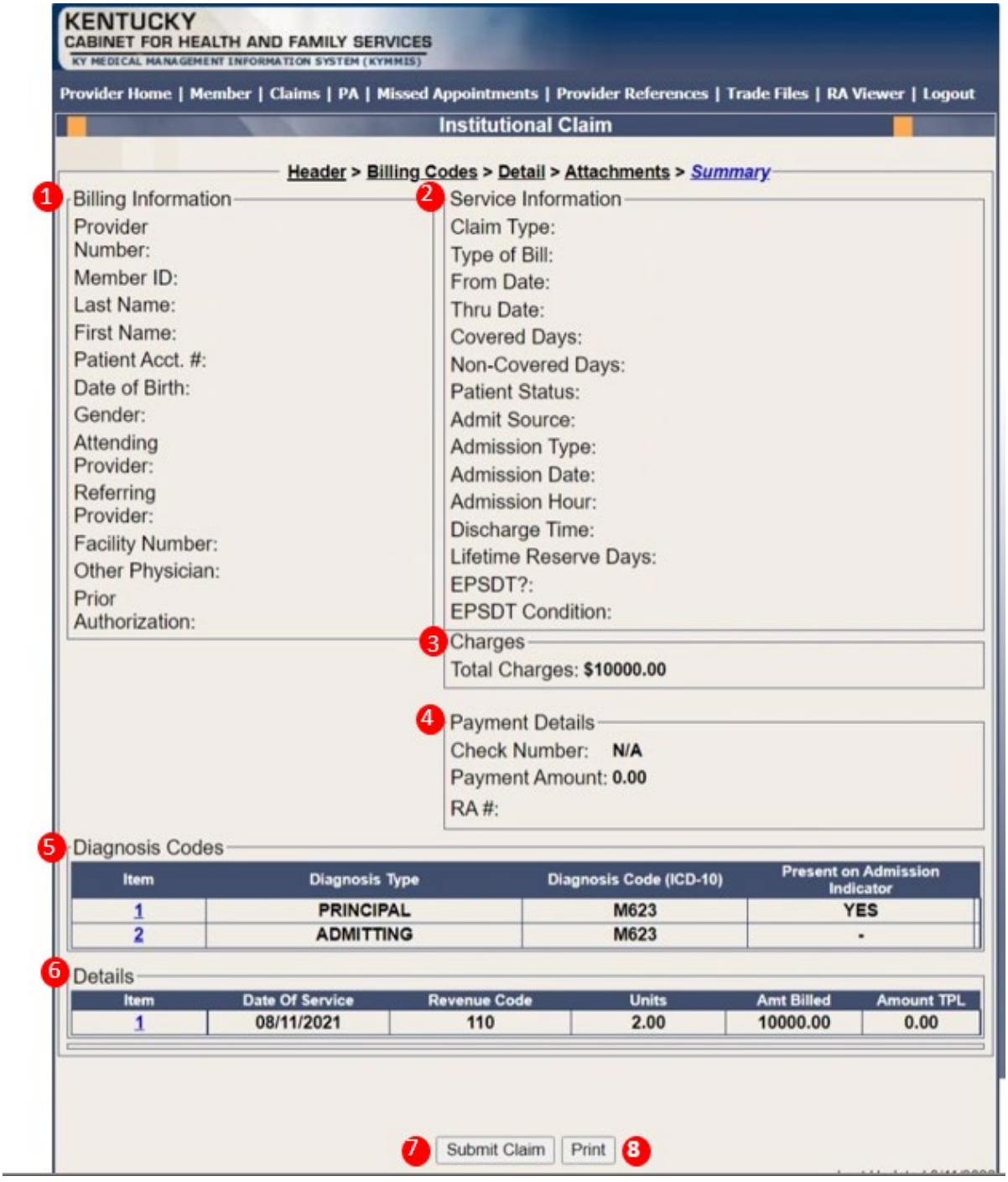
Item	From DOS	TO DOS	Procedure Code	Units Billed	Charges
1	01/30/2021	01/30/2021	99213	1.00	20.00
2	01/21/2021	01/21/2021	99213	1.00	10.00
3	01/22/2021	01/22/2021	99213	1.00	10.00

Print

10.2.6 Summary Panels

Summary Screen

Allows the user to verify the data before submitting the claim.

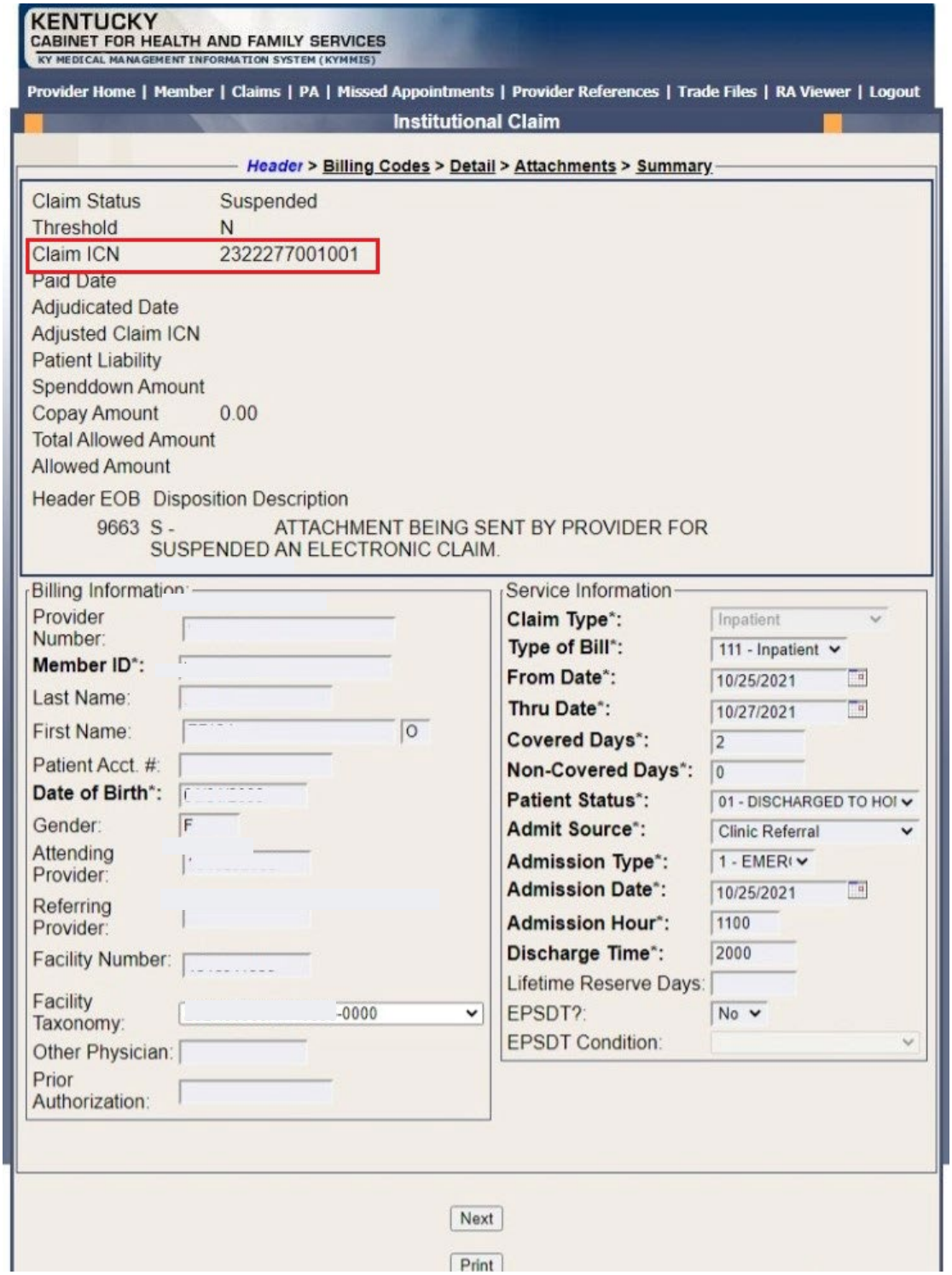


Summary Screen Field Descriptions

Field Number / Menu Selection	Definition of Field Description
1	**Billing Information** Identifies this section as the **Billing Information** section of the **Summary** screen.
2	**Service Information** Identifies this section as the **Service Information** section of the **Summary** screen.
3	**Claim Charges** Identifies this section as the **Claim Charges** section of the **Summary** screen.
4	**Payment Details** Identifies this section as the **Payment Details** section of the **Summary** screen.
5	**Diagnosis Codes** Identifies this section as the **Diagnosis Codes** section of the **Summary** screen.
6	**Details** Identifies this section as the **Details** section of the **Summary** screen. (Click the **Details Item** link to return to that detail.)
7	**Submit Claim** Click the **Submit Claim** button to finalize the claim.
8	**Print** Allows the user to print this screen.

Submitted Claim

Claim ICN region is 23, which denotes KYHealthNet claim **with** attachment.



10.2.7 Adjust or Void Claim Screen

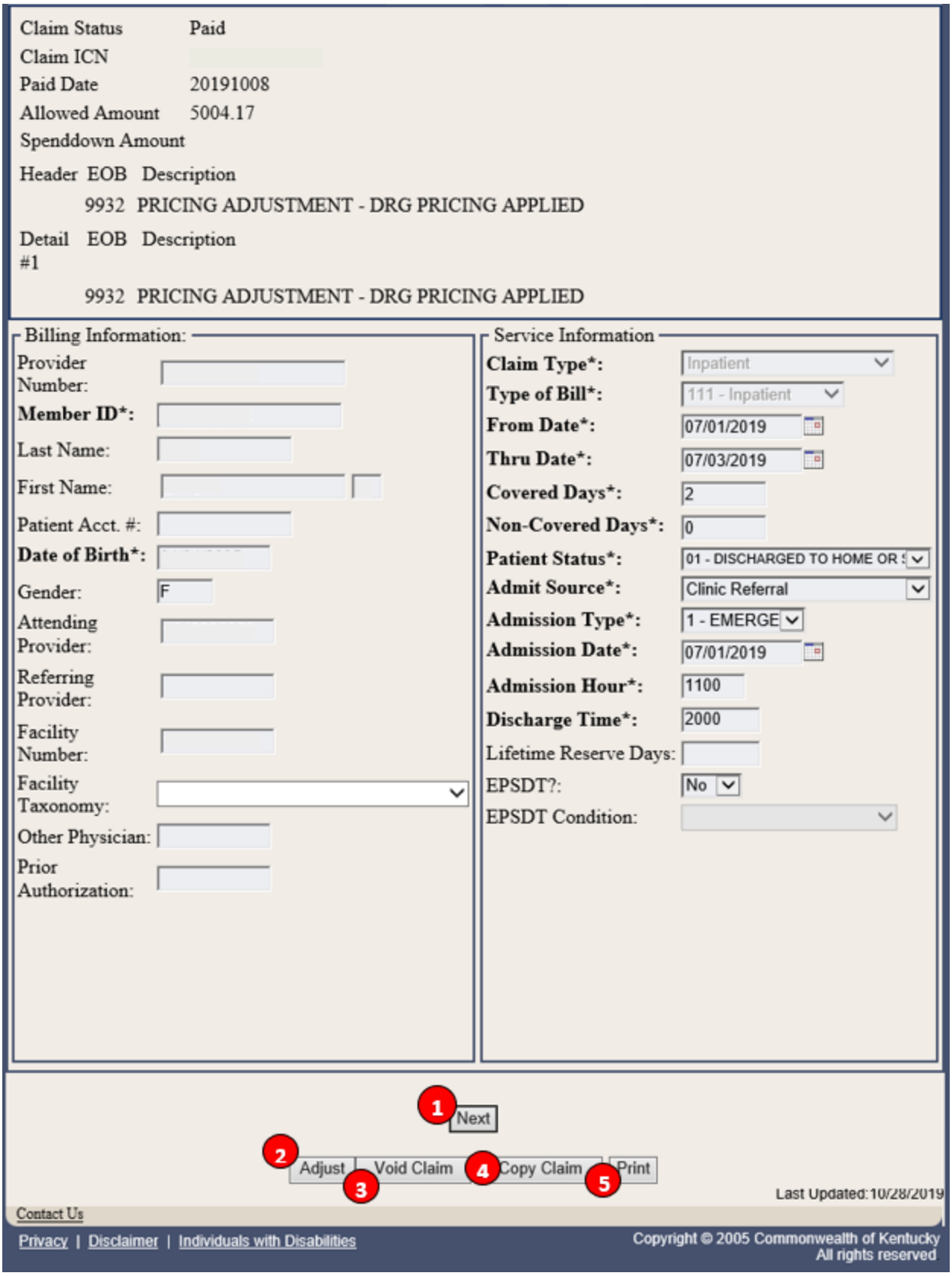
To ADJUST a paid claim:

1. Select **Claim Inquiry**.
2. Enter the Member information and dates of service or enter the claim Internal Control Number.
3. Click the **Next** button to advance.
4. Correct the information on the claim.
5. Save the updated information.
6. Click the **Adjust** button.

To VOID a paid claim:

1. Select **Claim Inquiry**.
2. Enter the Member information and dates of service or enter the claim Internal Control Number.
3. Click the **Next** button to advance.
4. Click the **Void Claim** button.

If the claim does not show an **Adjust** or **Void Claim** button, the claim was previously adjusted or voided.


Claim Status Paid
Claim ICN
Paid Date 20191008
Allowed Amount 5004.17
Spenddown Amount
Header EOB Description
9932 PRICING ADJUSTMENT - DRG PRICING APPLIED
Detail EOB Description
#1
9932 PRICING ADJUSTMENT - DRG PRICING APPLIED
Billing Information:
Provider Number:
Member ID*:
Last Name:
First Name:
Patient Acct. #:
Date of Birth*:
Gender: F
Attending Provider:
Referring Provider:
Facility Number:
Facility Taxonomy:
Other Physician:
Prior Authorization:
Service Information
Claim Type*: Inpatient
Type of Bill*: 111 - Inpatient
From Date*: 07/01/2019
Thru Date*: 07/03/2019
Covered Days*: 2
Non-Covered Days*: 0
Patient Status*: 01 - DISCHARGED TO HOME OR
Admit Source*: Clinic Referral
Admission Type*: 1 - EMERGE
Admission Date*: 07/01/2019
Admission Hour*: 1100
Discharge Time*: 2000
Lifetime Reserve Days:
EPSDT?: No
EPSDT Condition:
1
Next
2
Adjust
3
Void Claim
4
Copy Claim
5
Print
Last Updated:10/28/2019
Contact Us
Privacy | Disclaimer | Individuals with Disabilities
Copyright © 2005 Commonwealth of Kentucky
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Field Description	Definition of Field Description
1	**Next** Navigates the user through the claim.
2	**Adjust** Make the correction to adjust a paid claim. Click **Save** when a **Save** button is available.
3	**Void Claim** Click **Void Claim** to reverse a paid claim.
4	**Copy Claim** Click **Copy Claim** to copy the current paid claim.
5	**Print** Allows the user to print this screen.

10.2.8 Medicare Crossover

1. Follow the regular billing instructions for an Institutional claim submission.

    a. Under **Claim Type**, select either **Crossover (Inpatient or Long Term Care)** or **Crossover (Outpatient)**.

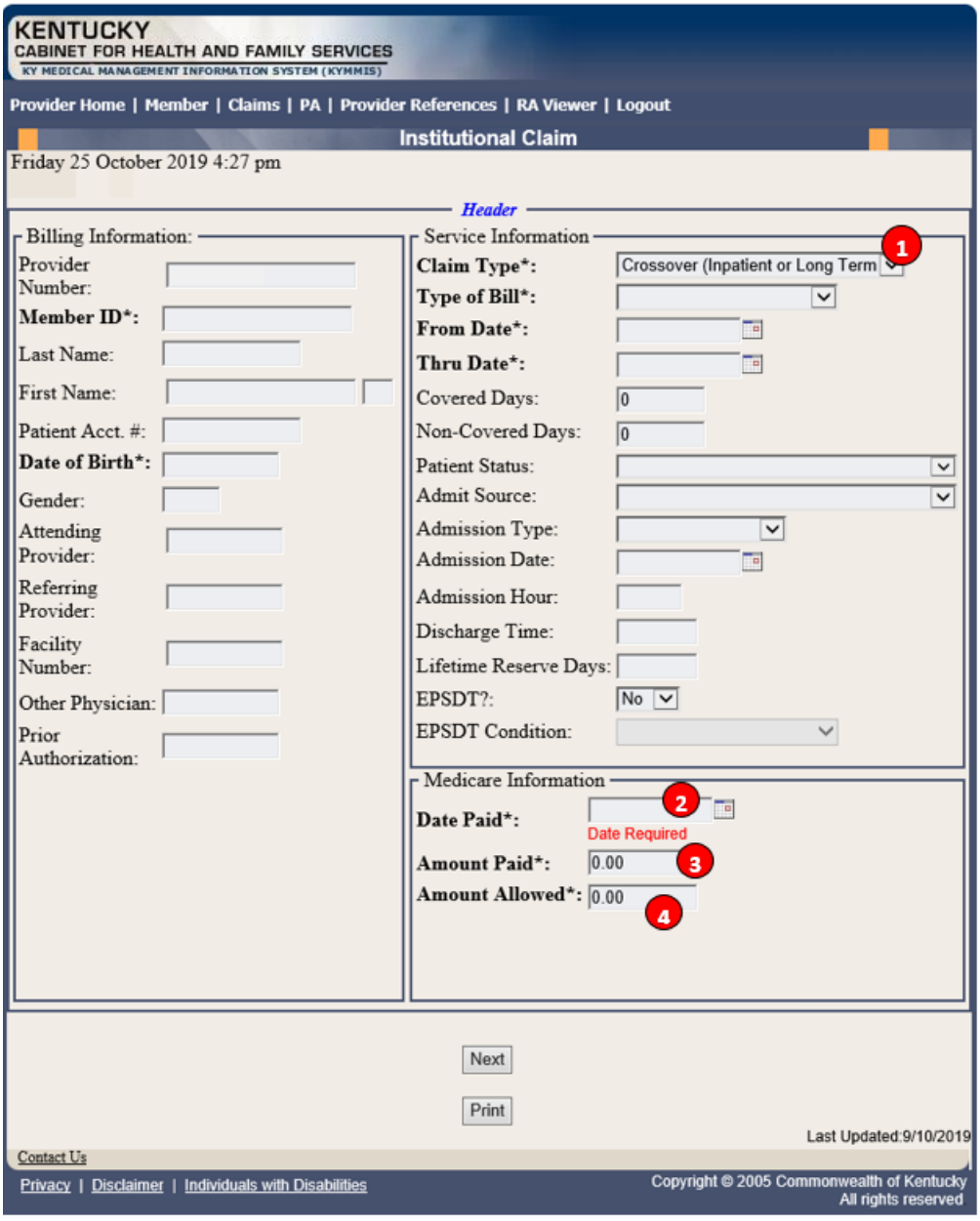
2. Continue with the regular instructions.

    a. Under **Medicare Information**, enter the following Medicare information from the Medicare EOMB:

- Date Paid
- Amount Paid

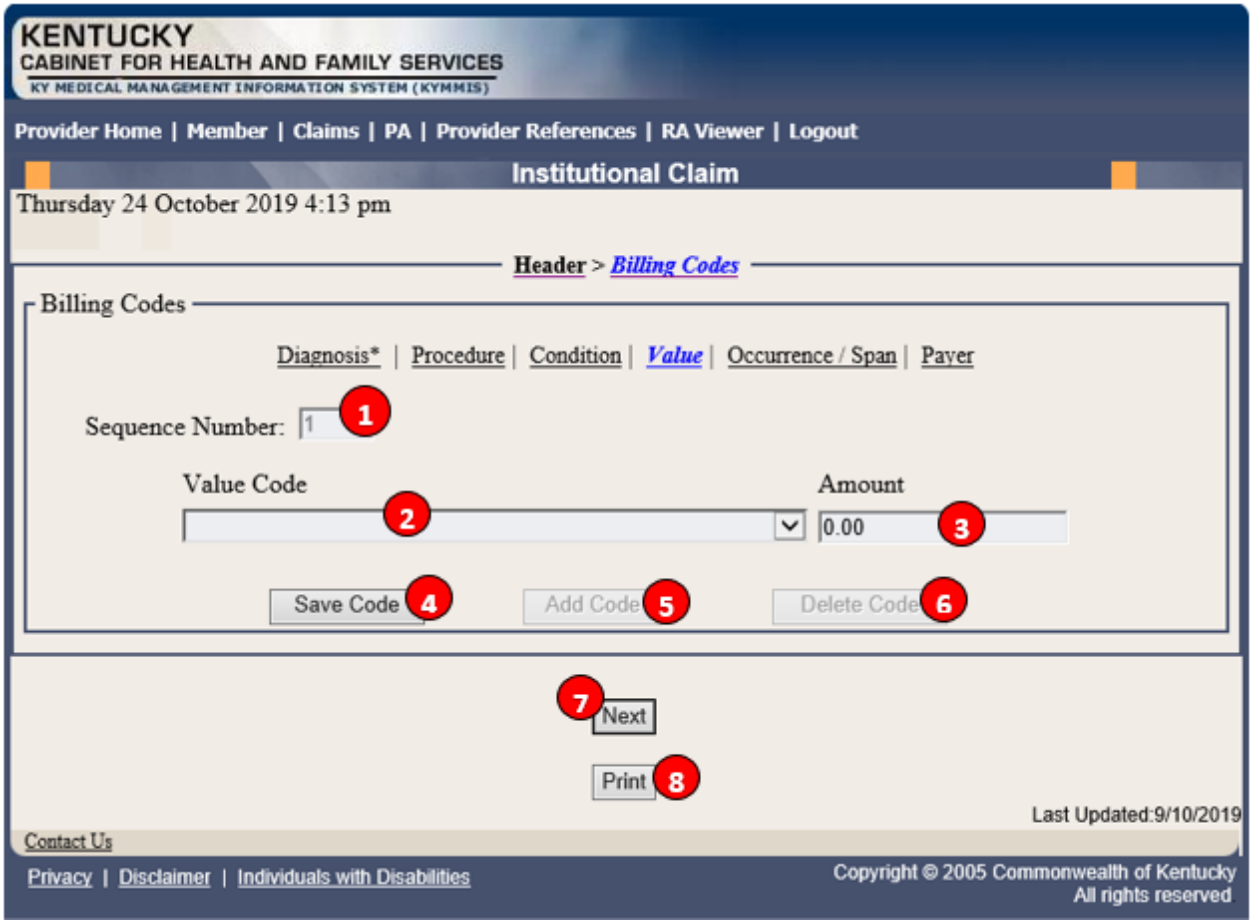
and

- Amount Allowed



Field Number / Menu Selection	Definition of Field Description
1	**Claim Type** Choose the applicable crossover claim type.
2	**Date Paid** Enter Medicare's paid date.
3	**Amount Paid** Enter the Medicare paid amount on the services being billed.
4	**Amount Allowed** Enter Medicare's allowed amount on the services being billed.

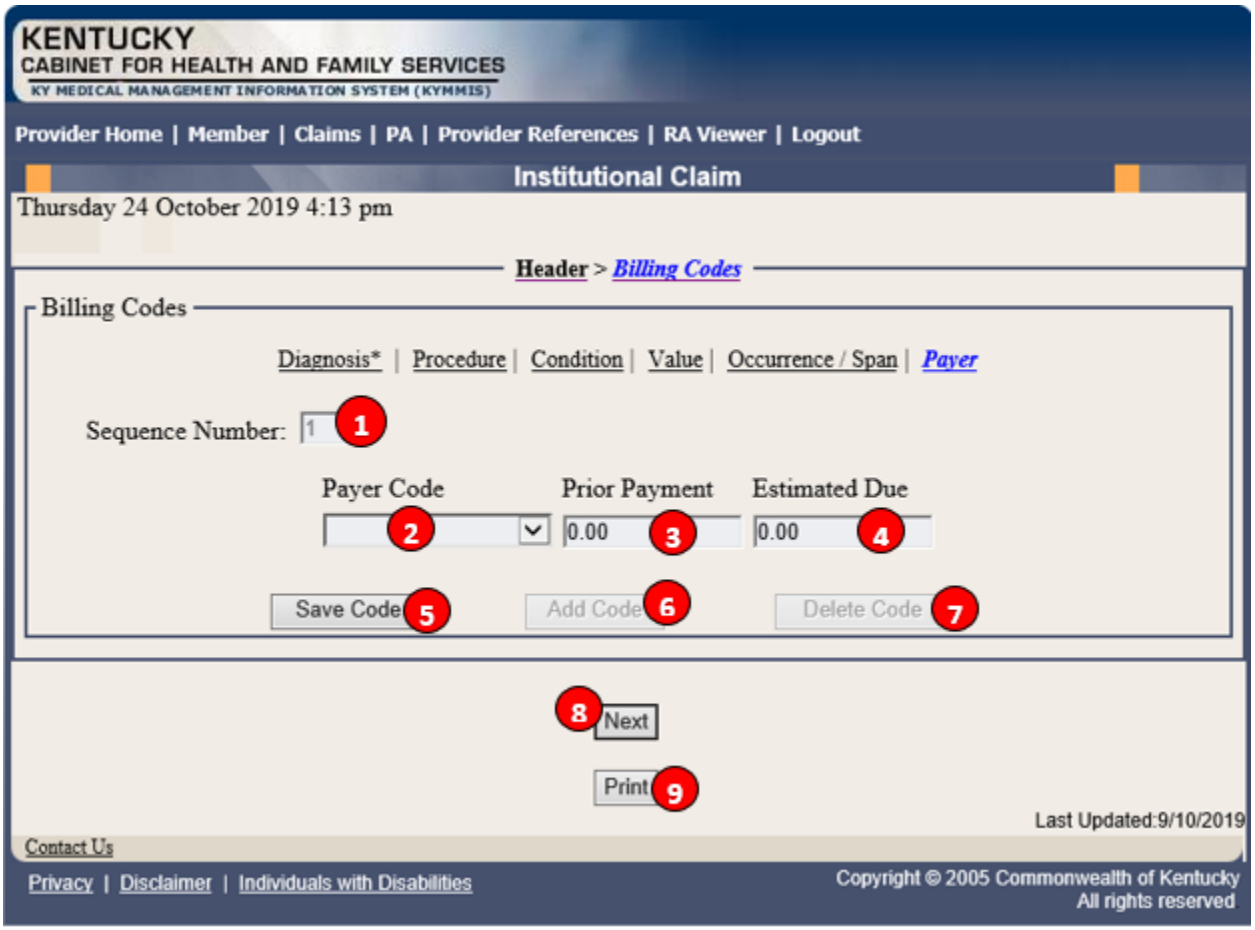
10.2.8.1 Billing Codes – Medicare, Value



Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the diagnosis. This field is auto-populated.
2	**Value Code (drop down)** Select **Co-Payment Payer A** or **Coinsurance Payer A** or **Deductible Payer A** from the drop down and enter the corresponding amount in field 3.
3	**Amount** Enter the corresponding dollar amount.
4	**Save Code** Saves the value code information on the claim. A save is required to continue.
5	**Add Code** Allows the user to add an additional value code to the claim. Save the code after each additional code is entered.

Field Number / Menu Selection	Definition of Field Description
6	**Delete Code** Allows the user to remove a value code previously entered on the claim.
7	**Next** Advance to the next screen.
8	**Print** Allows the user to print this screen.

10.2.8.2 Billing Codes – Medicare, Payer



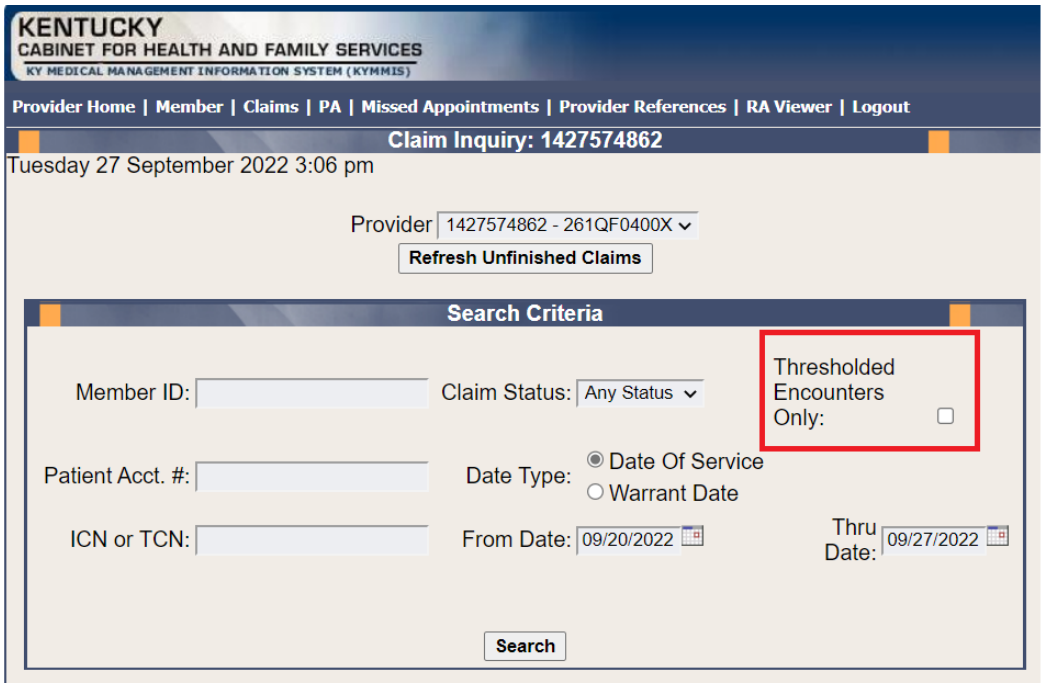
Field Number / Menu Selection	Definition of Field Description
1	**Sequence Number** The sequence number of the Payer. This field is auto-populated.
2	**Payer Code** Select **Medicaid**.
3	**Prior Payment** This field is auto-populated as **0.00**; leave as is.
4	**Estimated Due** Enter the estimated amount due from Kentucky Medicaid (the total of Medicare copay, coinsurance and deductible).
5	**Save Code** Saves the payer information on the claim.

Field Number / Menu Selection	Definition of Field Description
6	**Add Code** Allows the user to add an additional value code to the claim. Save the code after each additional code is entered.
7	**Delete Code** Allows the user to remove a value code previously entered on the claim.
8	**Next** Advance to the next screen.
9	**Print** Allows the user to print this screen.

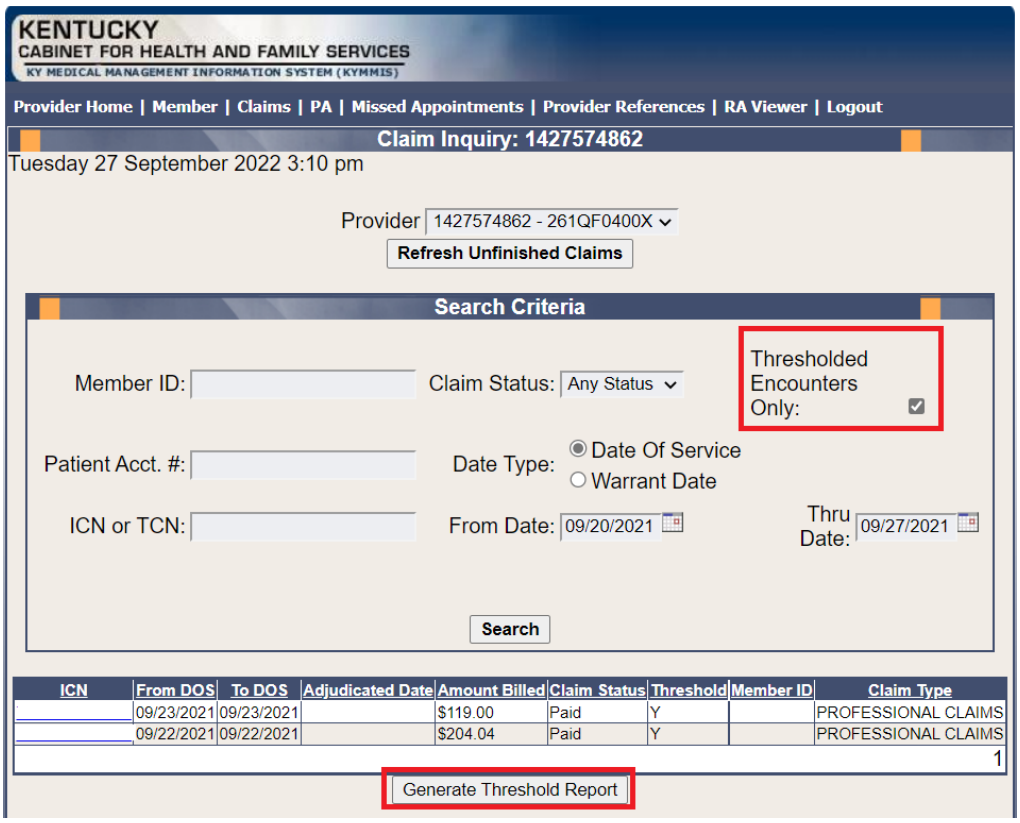
10.3 Thresholded Report

Located under Claim Inquiry

The **Thresholded Encounters Report** allows Primary Care Center (provider type 31) Rural Health Center (provider type 35) and Certified Community Behavioral Health Clinic (provider type 16) providers to run a report to view Thresholded Encounter data. The report is accessed through the Claims Inquiry page by selecting the Thresholded Encounters Only checkbox.



1. Select the checkbox Thresholded Encounters Only.
2. Enter additional search criteria
3. Select Search button



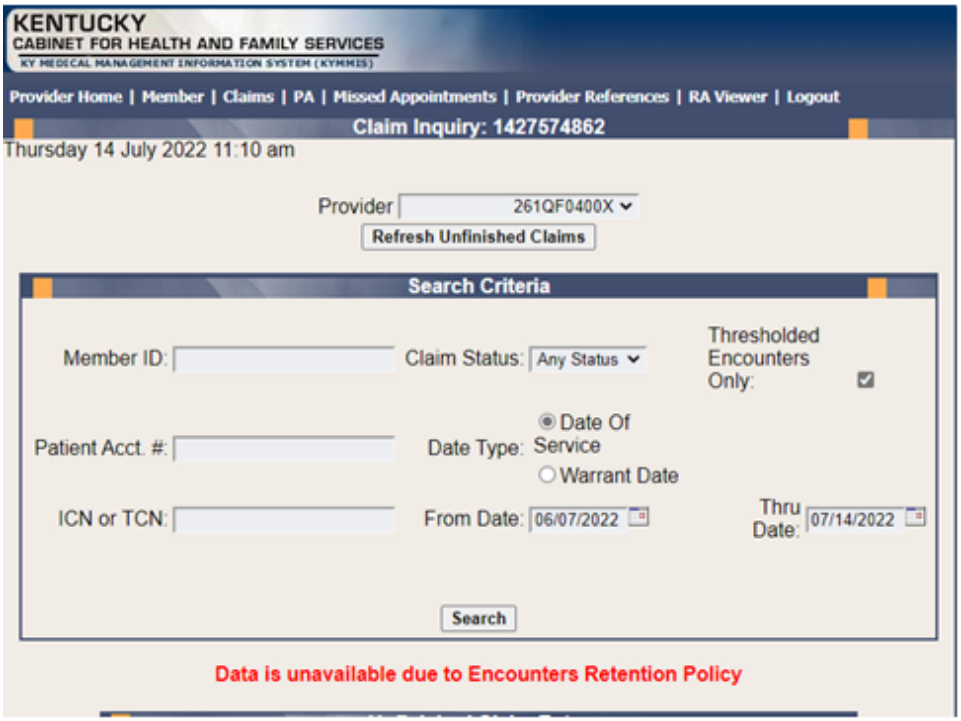
4. Select Generate Threshold Report
5. Report Returns

MMIS ICN	MCO ICN	MEMBER ID	THRESHOLD EOB	THRESHOLD EOB DSC	DTE BILLED	TDOS	FDOS	MRN	MCO MEMBER ID	SUBMITTER ID

Report Fields

- MMIS ICN
- Member ID
- Thresholded EOB
- Thresholded EOB Description
- Date Billed
- TDOS
- FDOS
- MRN
- MCO Member ID
- Submitter ID

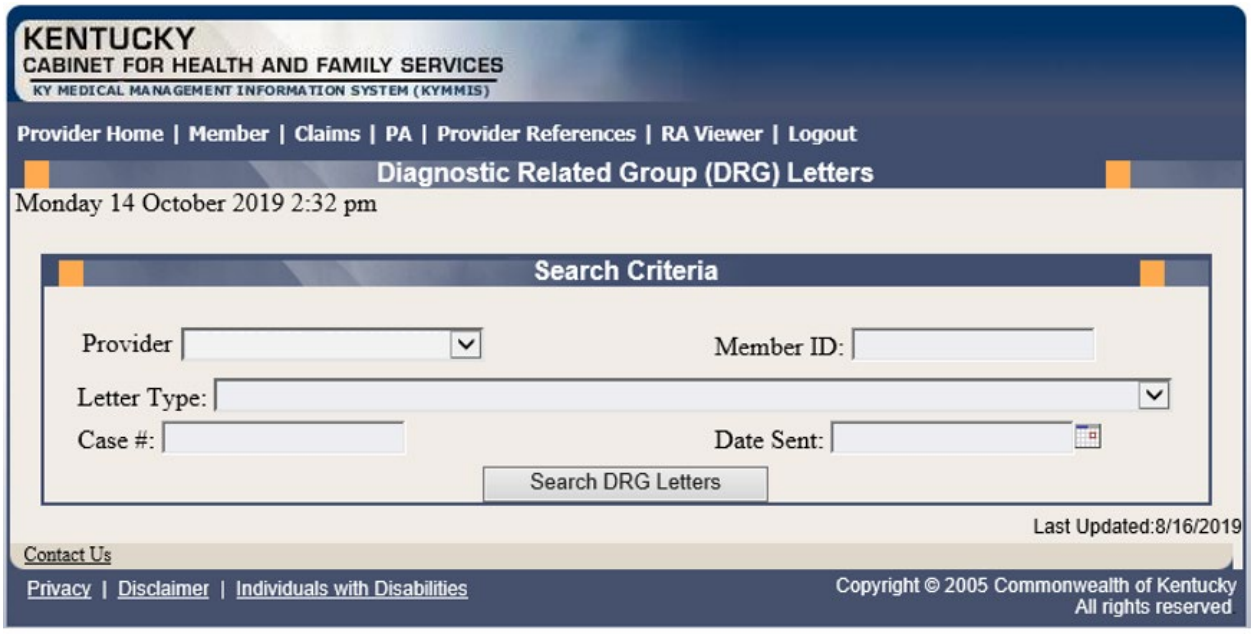
System Message: If the Thresholded Encounter Only checkbox is select but no results are returned the system will display the following Message: Data Is Unavailable Due To Encounters Retention Policy



10.4 DRG Letter

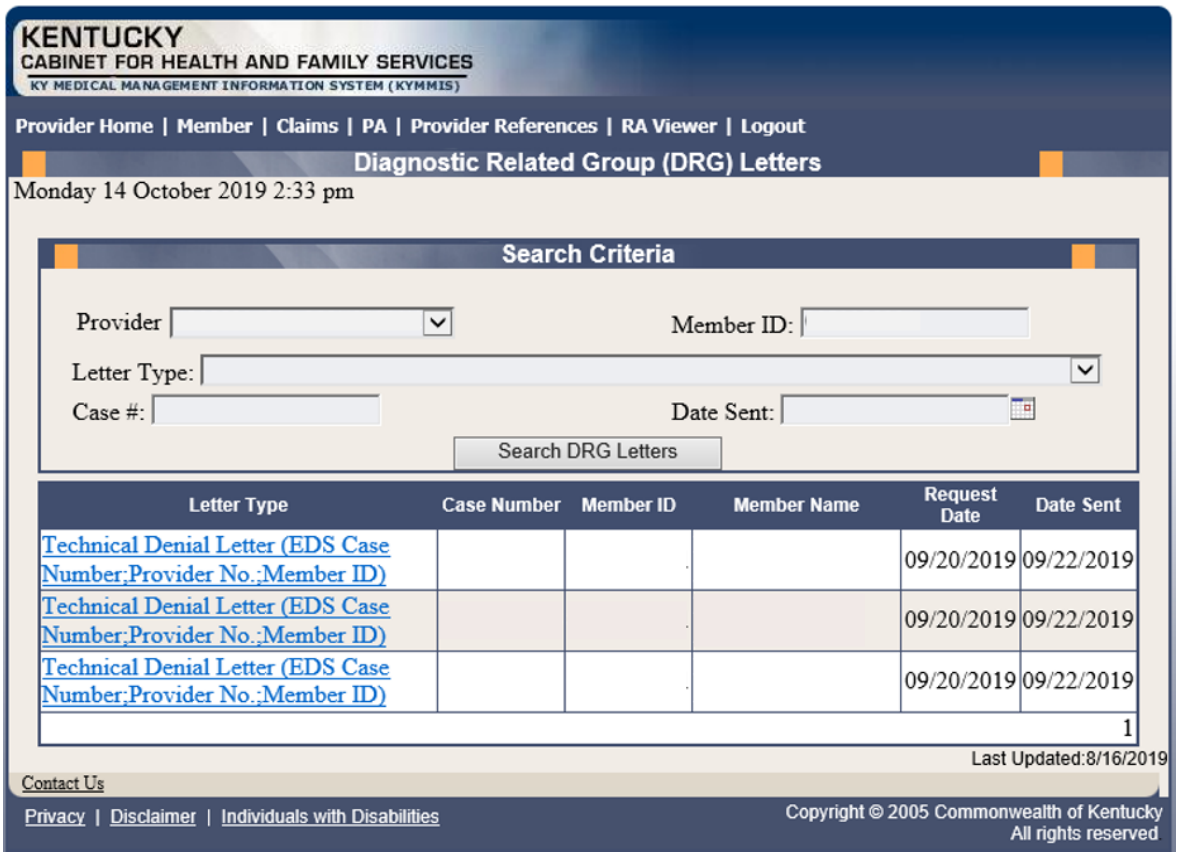
1. Select **Claims** from the menu.
2. Choose **DRG Letter** from the drop-down.

The following screen will appear.

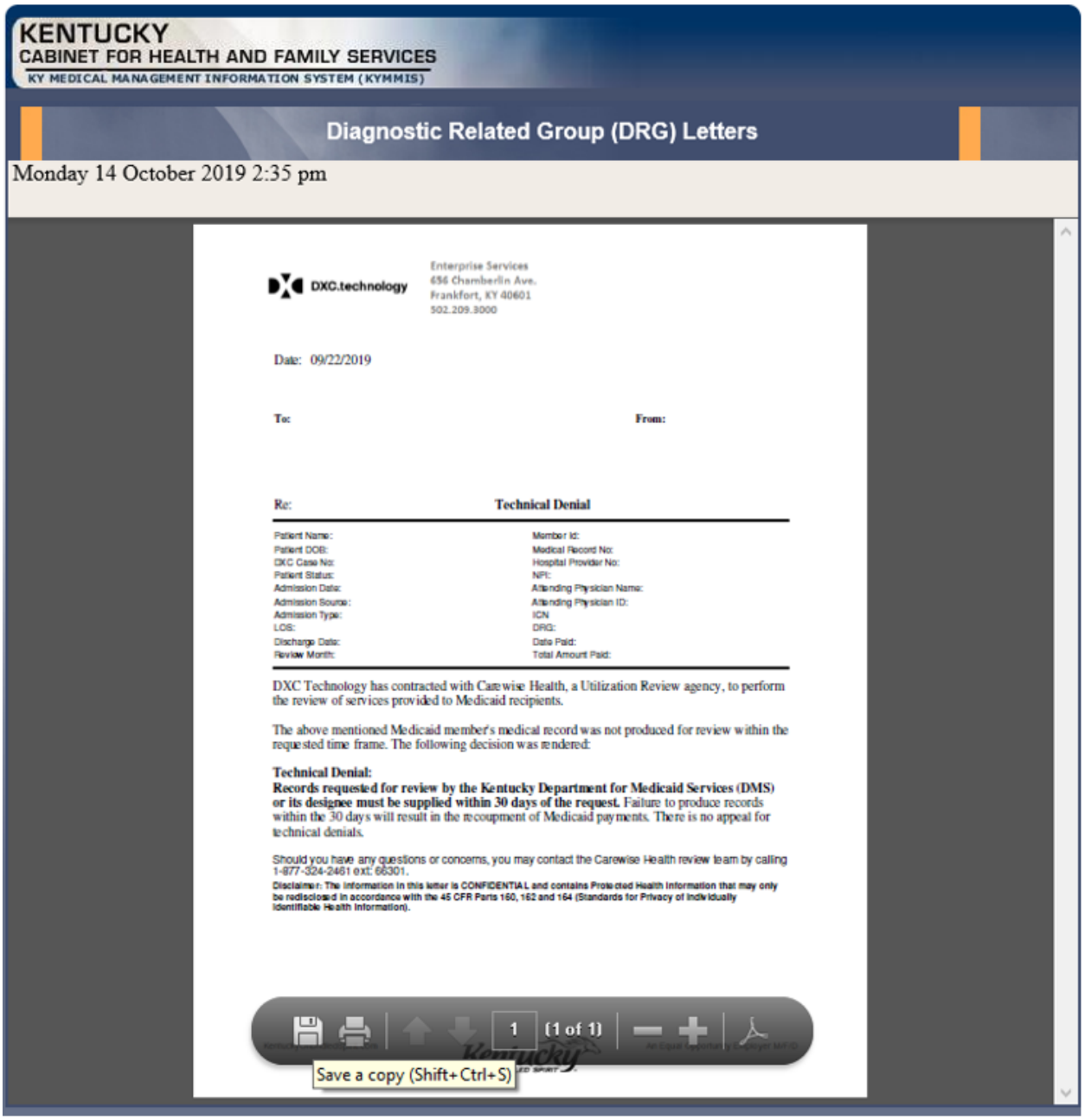


A Member ID, Letter Type, Case #, or Date Sent must be entered to limit the search parameters.

3. Click the **Search DRG Letters** button to return the data.



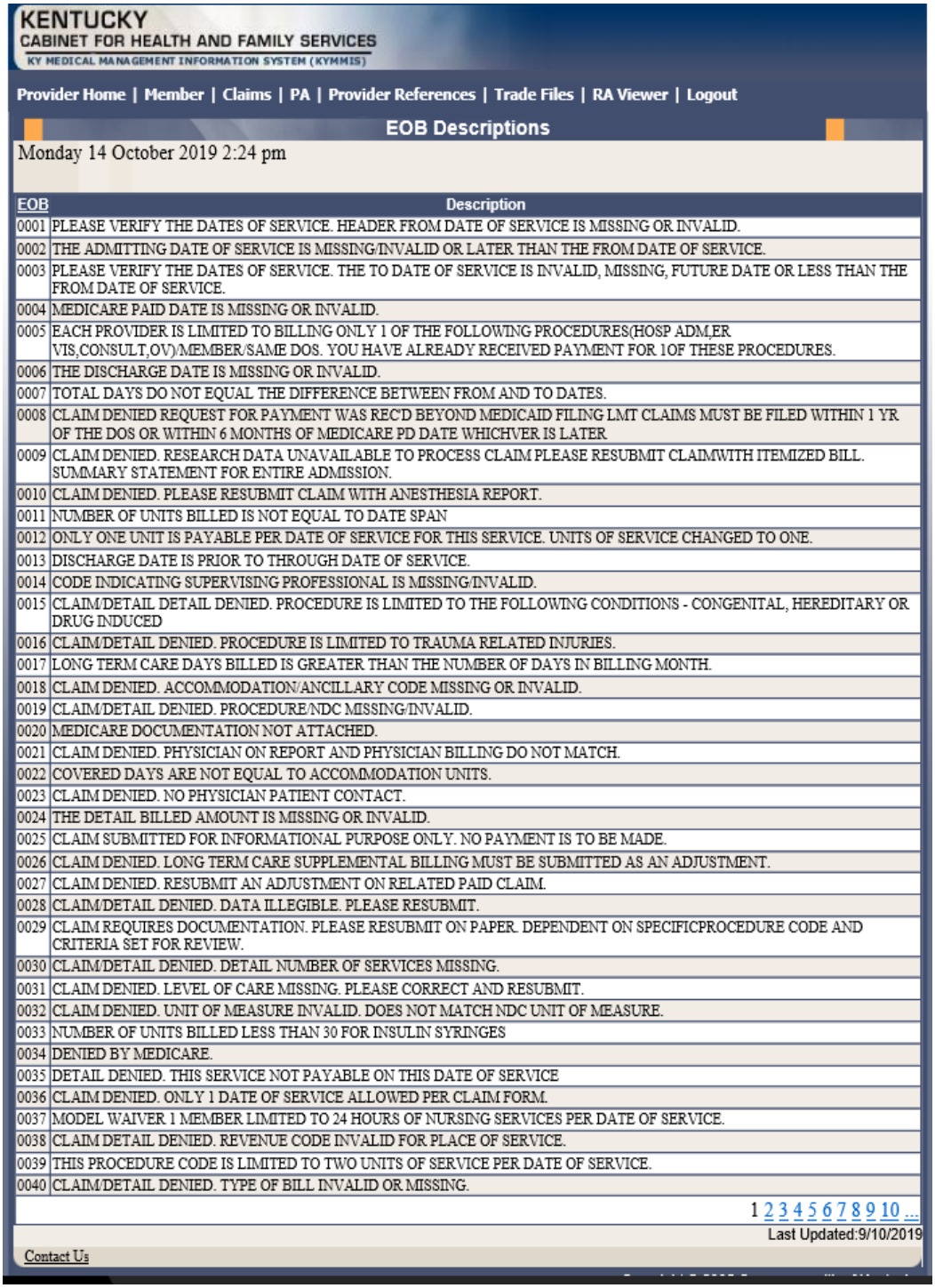
4. Click the link of the letter to view. The letter, with options to save or print, is displayed.



10.5 EOB Code Listing

1. Select **Claims** from the menu.
2. Choose **EOB Code Listing** from the drop-down.

This page lists all the EOB errors that are available in the MMIS.



KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
KY MEDICAL MANAGEMENT INFORMATION SYSTEM (KYMMIS)

Provider Home | Member | Claims | PA | Provider References | Trade Files | RA Viewer | Logout

EOB Descriptions

Monday 14 October 2019 2:24 pm

EOB	Description
0001	PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR INVALID.
0002	THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF SERVICE.
0003	PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, FUTURE DATE OR LESS THAN THE FROM DATE OF SERVICE.
0004	MEDICARE PAID DATE IS MISSING OR INVALID.
0005	EACH PROVIDER IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES(HOSP ADM,ER VIS,CONSULT,OV)/MEMBER/SAME DOS. YOU HAVE ALREADY RECEIVED PAYMENT FOR 1OF THESE PROCEDURES.
0006	THE DISCHARGE DATE IS MISSING OR INVALID.
0007	TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES.
0008	CLAIM DENIED REQUEST FOR PAYMENT WAS REC'D BEYOND MEDICAID FILING LMT CLAIMS MUST BE FILED WITHIN 1 YR OF THE DOS OR WITHIN 6 MONTHS OF MEDICARE PD DATE WHICHVER IS LATER
0009	CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIMWITH ITEMIZED BILL. SUMMARY STATEMENT FOR ENTIRE ADMISSION.
0010	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT.
0011	NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN
0012	ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVICE CHANGED TO ONE.
0013	DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE.
0014	CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID.
0015	CLAIM/DETAIL DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING CONDITIONS - CONGENITAL, HEREDITARY OR DRUG INDUCED
0016	CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES.
0017	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH.
0018	CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID.
0019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.
0020	MEDICARE DOCUMENTATION NOT ATTACHED.
0021	CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH.
0022	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
0023	CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT.
0024	THE DETAIL BILLED AMOUNT IS MISSING OR INVALID.
0025	CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE.
0026	CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT.
0027	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM.
0028	CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT.
0029	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFICPROCEDURE CODE AND CRITERIA SET FOR REVIEW.
0030	CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING.
0031	CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT.
0032	CLAIM DENIED. UNIT OF MEASURE INVALID. DOES NOT MATCH NDC UNIT OF MEASURE.
0033	NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES
0034	DENIED BY MEDICARE.
0035	DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE
0036	CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM.
0037	MODEL WAIVER 1 MEMBER LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVICE.
0038	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE.
0039	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE.
0040	CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING.

1 2 3 4 5 6 7 8 9 10 ...

Last Updated:9/10/2019

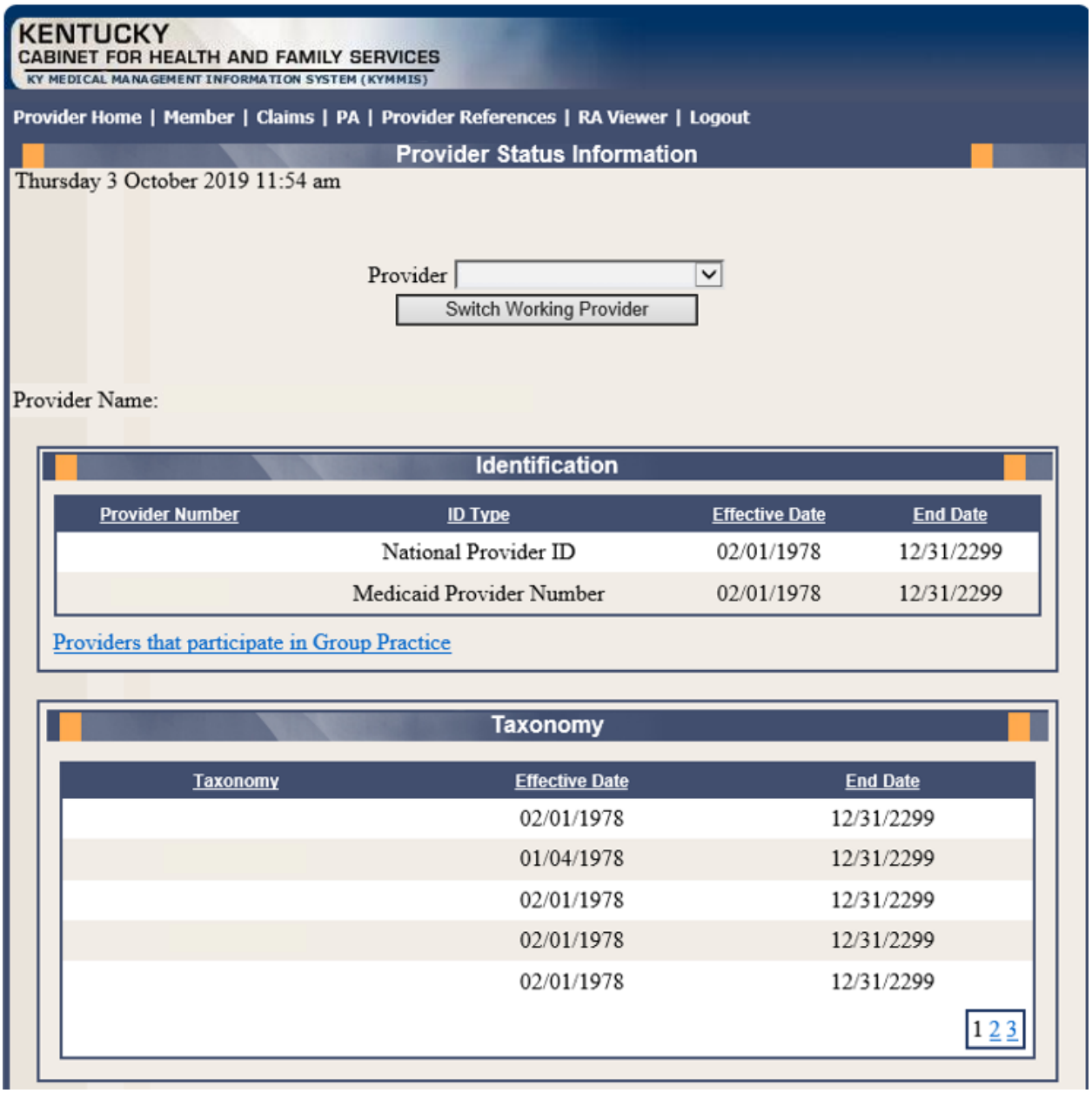
Contact Us

11 Provider Status

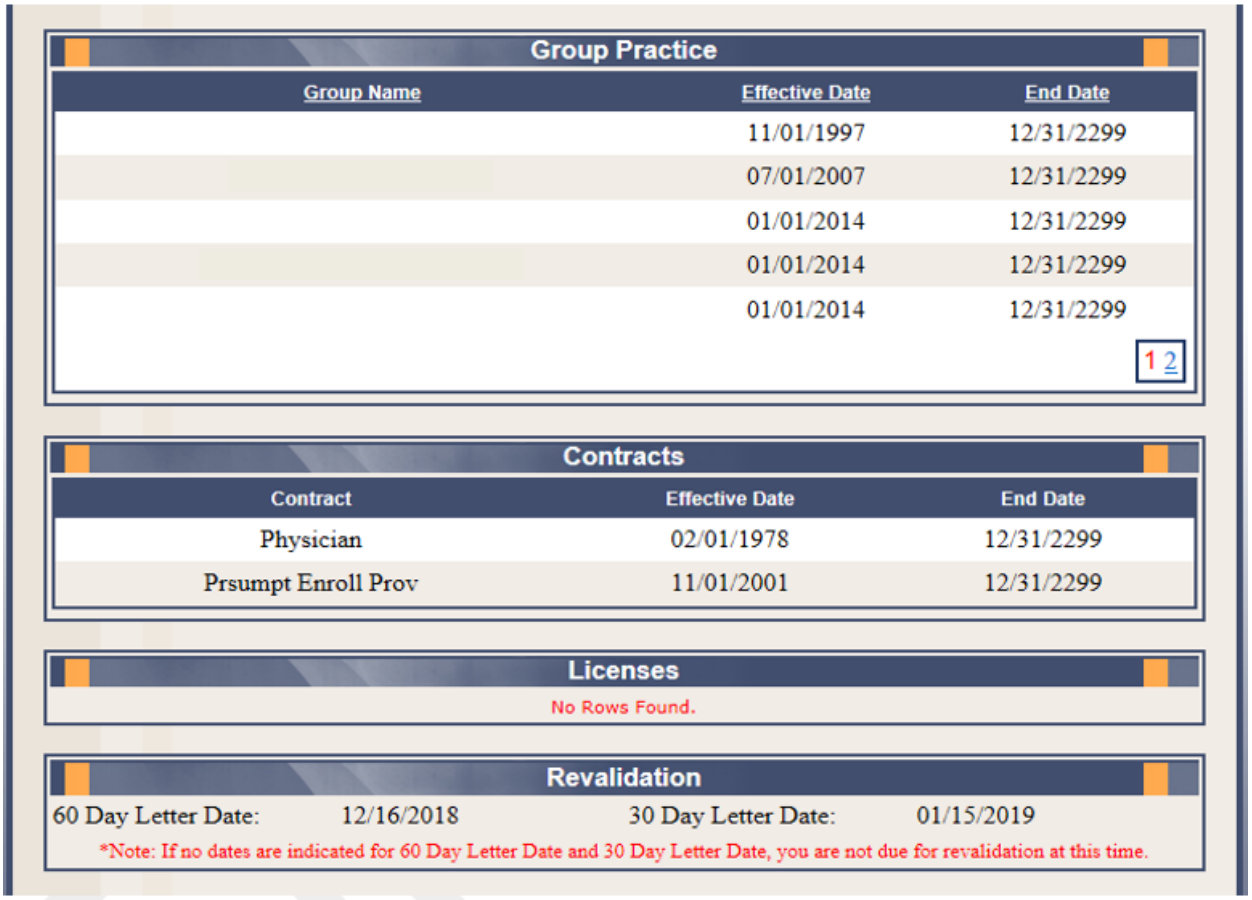
11.1 Provider Status Information

The **Provider Status Information** panel allows a user to view active provider status items from the provider file. Select the provider **NPI** and **Taxonomy** combination or the **KY Medicaid ID** from the drop-down selection to view provider status information covered in this section.

- The **Identification** panel is the provider's NPI and KY Medicaid provider number.
- The **Taxonomy** panel is the effective and end date of each taxonomy associate to the provider.



- The **Group Practice** panel is each individual provider effective and end dates linked to the group name (if applicable).
- The **Contracts** panel displays the current contract effective and end dates.
- The **Licenses** panel displays the provider's license number, state issued, effective date, and end date.
- The **Revalidation** panel displays when the revalidation application is due.



Group Practice

Group Name	Effective Date	End Date
	11/01/1997	12/31/2299
	07/01/2007	12/31/2299
	01/01/2014	12/31/2299
	01/01/2014	12/31/2299
	01/01/2014	12/31/2299

1 2

Contracts

Contract	Effective Date	End Date
Physician	02/01/1978	12/31/2299
Prsumpt Enroll Prov	11/01/2001	12/31/2299

Licenses

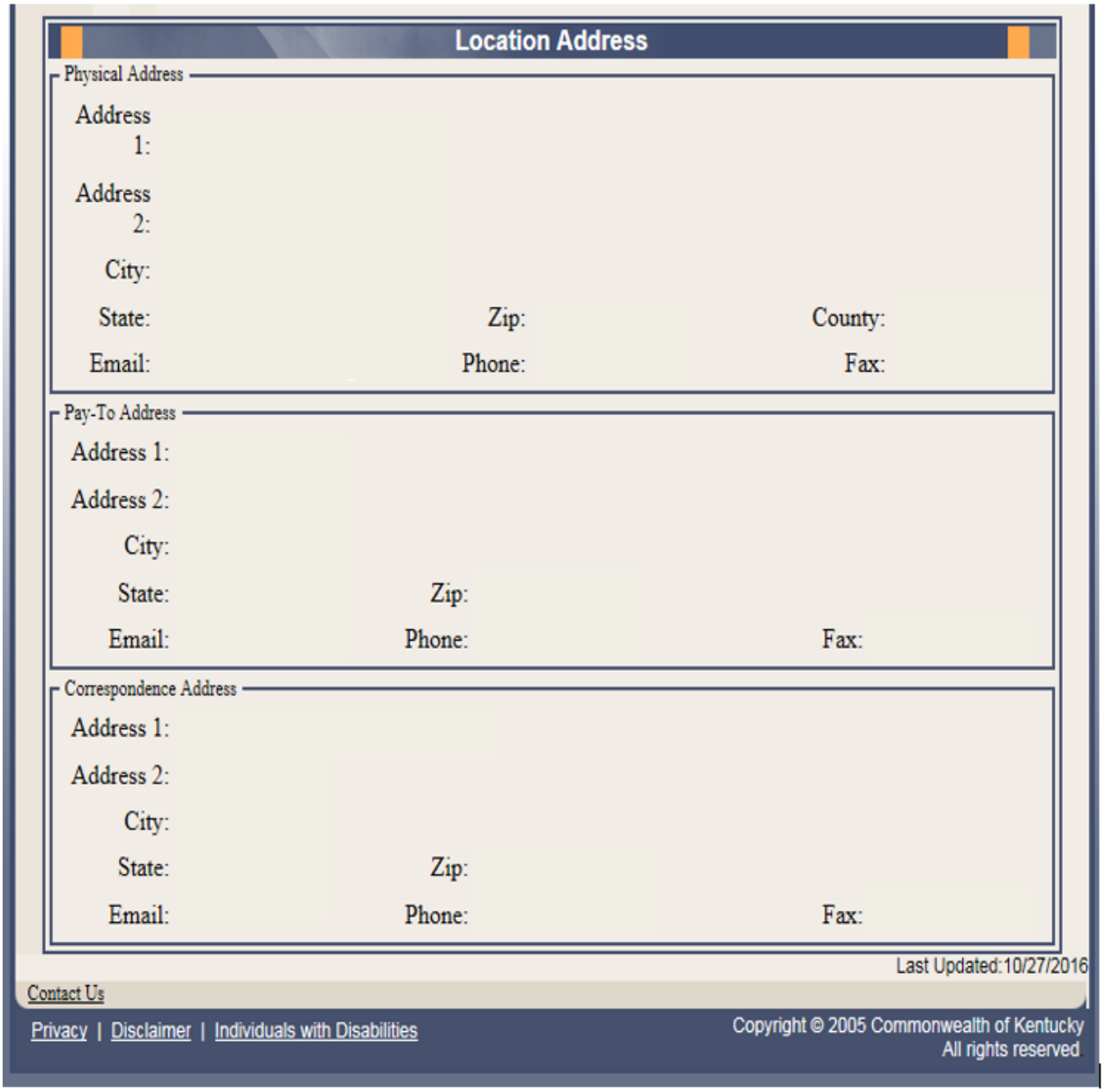
No Rows Found.

Revalidation

60 Day Letter Date: 12/16/2018 30 Day Letter Date: 01/15/2019

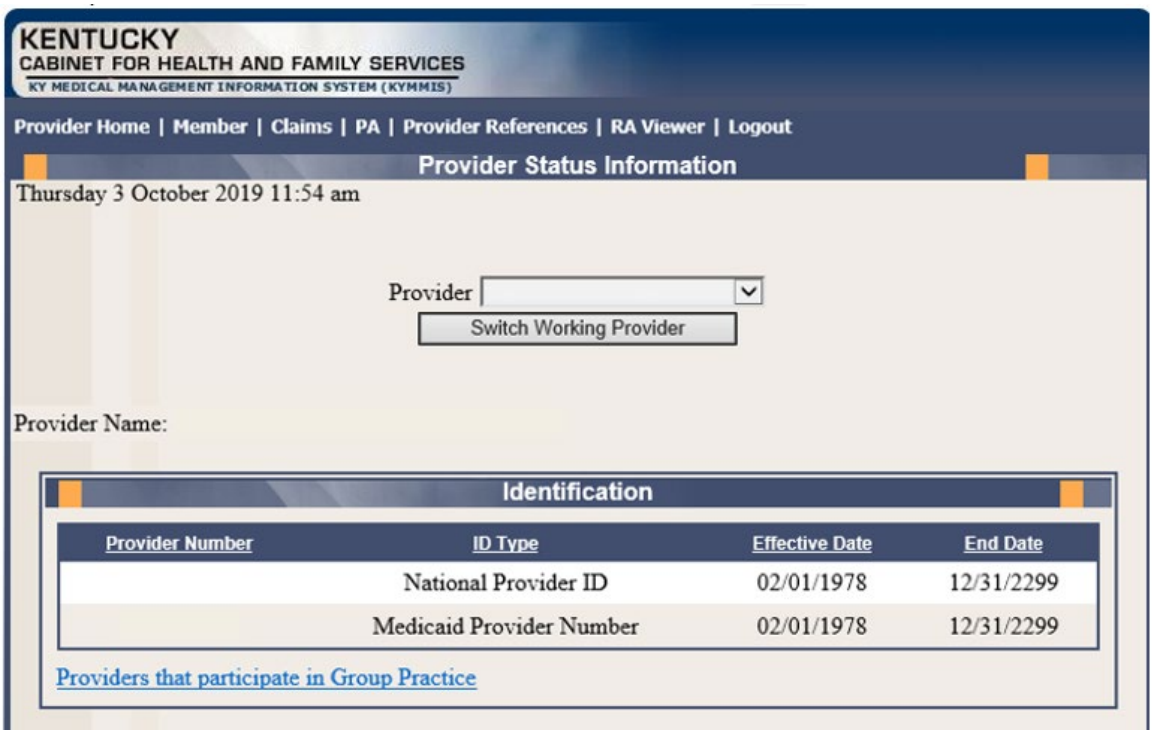
*Note: If no dates are indicated for 60 Day Letter Date and 30 Day Letter Date, you are not due for revalidation at this time.

- The **Location Address** panel displays the provider **Physical**, **Pay To**, and **Correspondence** addresses.

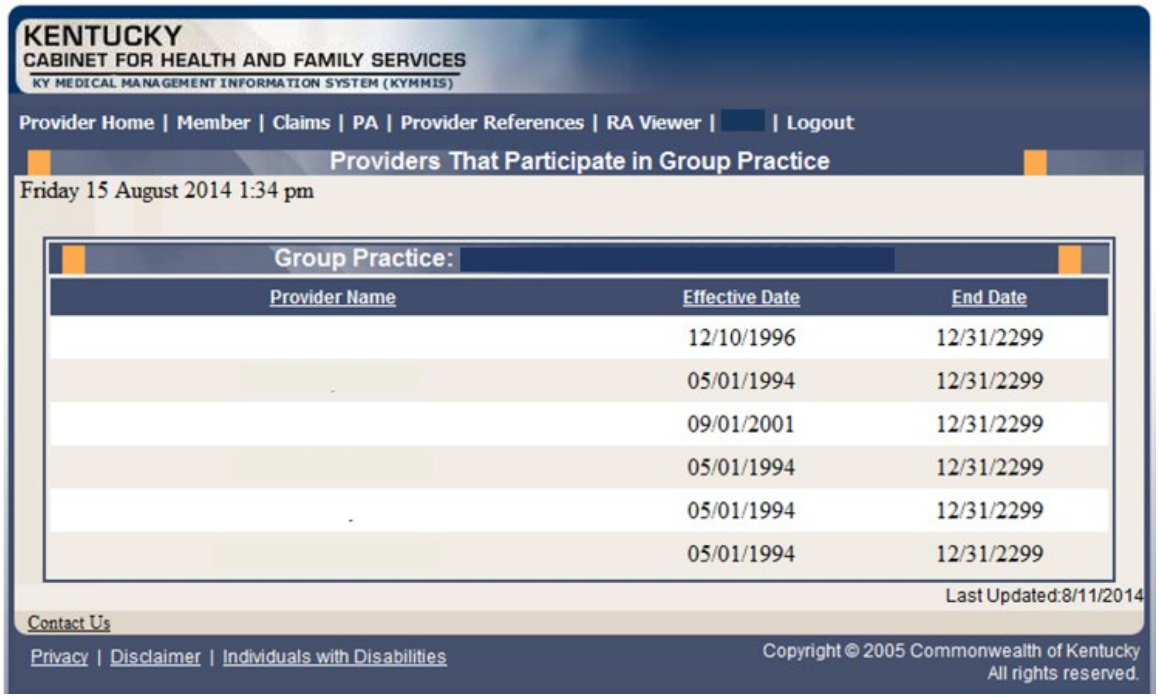


11.2 Provider Group Practice Hyperlink

If an individual provider is part of the Group Provider Practice, a link is available in the **Identification** section allowing the user to view active providers.



The user will click the link allowing access to the **Group Practice** information.



12 Appendix A

12.1.1 Forms

The web site link for a blank **PIN Release** form:

www.kymmis.com

1. Click **Electronic Claims**.
2. Click **EDI Forms**.
3. Click the link for the **PIN Release Form**.

12.1.2 Billing Instructions

www.kymmis.com

1. Click **Provider Relations**.
2. Click **Billing Instructions**.
3. Click **Provider Type**.