

**KENTUCKY MEDICAID PROGRAM  
POLICIES AND PROCEDURES MANUAL  
FOR  
TITLE V SERVICES PROVIDED BY  
THE DEPARTMENT FOR SOCIAL SERVICES**

**Cabinet for Health Services  
Department for Medicaid Services  
Frankfort, Kentucky 40621**

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TABLE OF CONTENTS

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	PAGE NO.
I. INTRODUCTION	1.1-1.2
A. Introduction	1.1
B. Fiscal Agent	1.2
II. KENTUCKY MEDICAID PROGRAM	2.1-2.10
A. General Information	2.1
B. Administrative Structure	2.2
C. Advisory Council	2.2-2.3
D. Policy	2.3-2.5
E. Public Law 92-603 (As Amended)	2.6-2.9
F. Appeal Process for Refund Requests	2.9-2.10
G. Timely Submission of Claims	2.10
H. Termination of Provider Participation	2.10
III. CONDITIONS OF PARTICIPATION	3.1-3.4
A. General Information	3.1
B. Provider Qualifications	3.1-3.2
C. Case Manager Qualifications	3 . 2
D. Rehabilitative Service Provider Qualifications	3.2-3.3
E. Client Qualifications	3.3
F. Client Records	3.3-3.4
IV. PROGRAM COVERAGE	4.1-4.5
A. Definition of Targeted Case Management Services	4.1-4.2
B. Limitations of Targeted Case Management Services	4.3
C. Client Rights	4.3
D. Rehabilitative Services	4.4-4.5
V. REIMBURSEMENT	5.1
A. Targeted Case Management Services	5.1
B. Rehabilitative Services	5.1

CABINET FOR HEALTH SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

TITLE V SERVICES PROVIDED BY DSS

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TABLE OF CONTENTS

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APPENDIX

- Appendix I - Provider Agreement (MAP-343)
- Appendix II - Provider Information Sheet (MAP-344)
- Appendix III - Provider Agreement Electronic Media Addendum (MAP-3 80)
- Appendix IV - Agreement Between the Kentucky Medicaid Program and  
Electronic Media Billing Agency (MAP-246)
- Appendix V - Medicaid Program Fiscal Agent Information

**INTRODUCTION**

**SECTION I**

SECTION I - INTRODUCTION

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A. INTRODUCTION

This manual provides for Title V Services Provided by Department for Social Services. The manual was formulated to provide Medicaid providers with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual shall provide basic information concerning coverage and policy. It shall assist providers in understanding what procedures are reimbursable, and shall 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 shall allow policy and procedural changes to be transmitted to providers in a form which may be immediately incorporated into the manual (i.e., page 4.6 might be replaced by new pages 4.6 and 4.7) after amendment process completed to corresponding administrative regulation.

Precise adherence to policy shall be imperative. In order that claims may be processed quickly and efficiently, it shall be extremely important that the policies and instructions described in this manual be followed. Any questions concerning agency policy shall be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health Services, 275 East Main Street, Frankfort, Kentucky 4062 1, 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 Program Services, Department for Medicaid Services, Cabinet for Health Services, 275 East Main Street, Frankfort, Kentucky 4062 1, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims shall be directed to the Kentucky Medicaid fiscal agent (see Appendix: Kentucky Medicaid Fiscal Agent).

SECTION I - INTRODUCTION

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B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients. Information regarding the fiscal agent shall be included in the Appendix.

**KENTUCKY MEDICAID PROGRAM**

**SECTION II**

SECTION II - KENTUCKY MEDICAID PROGRAM

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II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program shall be administered by the Cabinet for Health Services, Department for Medicaid Services. The Medicaid Program, identified in Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the Health Care Financing Administration.

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

The Department for Medicaid Services shall be bound by both federal and state statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program, Title XIX, shall not be confused, with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons sixty-five (65) years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to this program shall be specified in the body of this manual in Section IV.



SECTION II - KENTUCKY MEDICAID PROGRAM

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B. Administrative Structure

The Department for Medicaid Services of the Cabinet for Health Services shall bear 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 fiscal agent for the Department for Medicaid Services shall make the payments to the providers of medical services who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits shall be a responsibility of the local Department for Social Insurance offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program shall be 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 shall be composed of eighteen (18) members, including the Secretary of the Cabinet for Health Services, who serves as an *exofficio* member. The remaining seventeen (17) members shall be appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and shall be appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members shall be citizens of Kentucky who share a basic concern for health care in this state.

In accordance with the statutes, the Advisory Council shall meet at least every three (3) months or as often as deemed necessary to accomplish their objectives.

SECTION II - KENTUCKY MEDICAID PROGRAM

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In addition to the Advisory Council, the statute includes a provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees shall be decided by the professional organization that the technical advisory committee represents. The technical advisory committees shall provide for a broad professional representation to the Advisory Council.

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

D. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients.

The 1967 amendments to the Social Security Law stipulate that Title XIX Programs have secondary liability for medical costs of program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. The Medicaid Program shall have secondary liability. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

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:

SECTION II - KENTUCKY MEDICAID PROGRAM

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All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Medicaid Program. From those professionals who have chosen to participate, the recipient shall select the provider from whom the recipient wishes to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

Providers of medical services or authorized representatives shall attest, by their signatures, that the presented claims shall be valid and in good faith. Fraudulent claims shall be punishable by fine or imprisonment, or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

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

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. If computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

SECTION II - KENTUCKY MEDICAID PROGRAM

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

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

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

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

Provided services shall be periodically reviewed for recipient and provider abuse. Willful abuse by the provider may result in suspension from Program participation. Abuse by the recipient may result in placement of the recipient into a managed care program or a restricted program such as the Lock-In Program.

Claims shall not be paid for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Medicaid Program.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of his liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

SECTION II - KENTUCKY MEDICAID PROGRAM

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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,

SECTION II - KENTUCKY MEDICAID PROGRAM

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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 of 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--

SECTION II - KENTUCKY MEDICAID PROGRAM

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(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, services, 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 have 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 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

SECTION II - KENTUCKY MEDICAID PROGRAM

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(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 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,

(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. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in refund request(s).

If a refund request occurs subsequent to a postpayment review by the Surveillance and Utilization Review Branch (SURS), the provider may submit a refund to the Kentucky State Treasurer or appeal- the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to:

DIVISION OF PROGRAM SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
CABINET FOR HEALTH SERVICES  
THIRD FLOOR EAST  
275 EAST MAIN STREET  
FRANKFORT KY 4062 1



SECTION II - KENTUCKY MEDICAID PROGRAM

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If no response (refund or appeal) has been filed with Medicaid by the physician within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

G. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than 12 months from the date of service." Received is defined in 42 CFR 447.45 (d) (5) as follows, "The date of receipt shall be the date the agency received the claim as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid's fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. ONLY twelve (12) months shall elapse between EACH RECEIPT of the aged claim by the Program.

H. Termination of Provider Participation

Termination of a provider participating in the Medicaid Program shall be in accordance with the Department for Medicaid Services' administrative regulations which address the terms and conditions for provider termination and procedures for provider appeals.

**CONDITIONS OF PARTICIPATION**

**SECTION III**

SECTION III - CONDITIONS OF PARTICIPATION

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III. CONDITIONS OF PARTICIPATION

A. General Information

Effective July 1, 1996, Medicaid covered services performed by the Department for Social Services (DSS) shall be billable services. The services covered are targeted case management services and rehabilitative services.

B. Provider Qualifications

Provider participation shall be the Department for Social Services (DSS) as the state agency responsible for the provision of child and adult protective services, which includes children in the custody of or under the supervision of, or at risk of being in the custody of the State and adults who may receive protective services from the State as a component of the Title V Maternal and Child Health Program.

To receive certification as a Medicaid provider, the provider shall meet the following criteria:

1. Demonstrated capacity to provide all care elements of case management including:
  - a. assessment;
  - b. services plan development;
  - c. coordination of services; and
  - d. reassessment and follow-up.
2. Demonstrated case management experience in coordinating and linking community resources as required by the target population.
3. Demonstrated experience with the target population.
4. Shall have an administrative capacity to insure quality of services in accordance with state and federal requirements.

SECTION III - CONDITIONS OF PARTICIPATION

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5. Shall have a financial management system that provides documentation of services and costs.
6. Shall have a capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902(a) (23) of the Act, freedom of choice provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

C. Case Manager Qualifications

The Case manager shall have, at a minimum:

1. A Bachelor of Arts or Bachelor of Science degree in any of the social/behavioral sciences or related fields from an accredited institution; and
2. One (1) year experience working directly with the targeted population or performing case management services. A master's degree in a human service field can substitute for the one (1) year experience.

D. Rehabilitative Service Provider Qualifications

1. Board eligible or Board certified psychiatrist; or
2. Clinical psychologist, as defined in KRS 20:091; or
3. Psychiatric nurse, as defined in KRS 20:091; or
4. Qualified Social Worker (or Master's Degree in Social Work), as defined in KRS 20:091.

SECTION III - CONDITIONS OF PARTICIPATION

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5. Other Staff: Direct care staff who are under the general supervision of one of the above-referenced professionals.
6. Supervision shall consist of authorization of initial treatment plans and any changes made in treatment plans, consultation, and a review of treatment plans at least once every six (6) months.

E. Client Qualifications

1. Targeted Case Management services shall be limited to:
  - a. Medicaid eligible children under the age of twenty-one (21) who meet the DSS's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the State,
  - b. Medicaid eligible adults (persons twenty-one (21) years of age or older) who meet DSS's conditions and circumstances to be defined as an adult in need of protective services.
2. Rehabilitative services shall be limited to Medicaid eligible children under the age of twenty-one (21) who meet the DSS's conditions and circumstances as a child in the custody of or at risk of being in the custody of the State.

F. Client Records

Client records shall substantiate the services billed to Medicaid. Records shall include the type of service provided, the date of service, place of service, and the person providing the service. All records shall be personally signed, or co-signed by supervising professional, if required, and dated by the provider of the service.

SECTION III - CONDITIONS OF PARTICIPATION

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Client records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments shall be maintained in an organized central file and furnished to the Cabinet for Health Services upon request and made available for inspection and copying by Cabinet personnel. All records are subject to postpayment review.

**PROGRAM COVERAGE**

**SECTION IV**

SECTION IV - PROGRAM COVERAGE

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IV. PROGRAM COVERAGE

The services covered include targeted case management and rehabilitative services.

A. Definition of Targeted Case Management

Case Management services are defined as services which will assist the targeted population in gaining needed medical, educational, social, and other support services. These services are performed by qualified case managers and shall include:

1. A written comprehensive needs assessment, which shall be obtained by face-to-face contact with the child, adult, his family, or other collaterals needed to determine the individual's needs;
2. Participation in the development of the individual's treatment plan;
3. Coordination of and arranging for needed services as identified in the individual's treatment plan;
4. Assisting the individual and his family or person in custodial control in accessing needed services (both Medicaid and non-medical) as provided by a multiplicity of agencies and programs;
5. Monitoring the individual's progress through the full array of services by:
  - a. Making referrals;
  - b. Tracking the individual's appointments;
  - c. Removing any barriers which prohibit access to the recommended programs or services;



SECTION IV - PROGRAM COVERAGE

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- d. Performing follow-up on services rendered to assure the services are received and meet the individual's needs;
  - e. Performing periodic re-assessments of the individual's changing needs; and
  - f. Educating the family or individual of the value of early intervention services and treatment programs.
- 6. Performing advocacy activities on behalf of the individual. The case manager may intercede to assure appropriate, timely, and productive treatment modalities;
  - 7. Establishing and maintaining current client records, documenting contracts, services needed, client's progress, and any other information as may be required;
  - 8. Providing case consultations as required (i.e., consulting with a services provider to assist in determining the individual's progress, etc.); and
  - 9. Providing crisis assistance (i.e., **intervention on** behalf of the individual, making arrangements for emergency referrals and treatment, and coordinating any other needed emergency services).

SECTION IV - PROGRAM COVERAGE

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**B.** Limitations of Targeted Case Management Services

Case Management services do not include:

1. The actual provisions of treatments;
2. Outreach activities to potential clients;
3. Administrative activities associated with Medicaid eligibility determinations, application processing, etc.;
4. Institutional Discharge Planning - This service is required as a condition of payment for institutional (hospital, nursing facilities) services and therefore, shall not be covered under the Targeted Case Management Program. The case management provider may bill, however, for Case Management services performed either in the month prior to or month of discharge from the facility to prepare for the individual's return to the community;
5. Transportation services solely for the purpose of transporting the individual; and
6. Payment for Case Management services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

**C.** Client Rights

1. Clients shall have the freedom of choice of Case Management services;
2. Clients shall be allowed to have free choice of service providers of any other Medicaid-covered services.

SECTION IV - PROGRAM COVERAGE

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D. Rehabilitative Services

Rehabilitative Services shall include at least the following:

1. Treatment, planning, and support activities which assist the child in gaining access to necessary care and services as described in the child's individual treatment plan. These services include:
  - a. Intake and Assessment: Identifying and reassessing the child's medical, social, educational, and other needs through face-to-face contact with the child, the child's family, and through consultation with other professionals.
  - b. Development of the treatment plan: Determining with the child, family, guardians, or other professionals what services and resources are necessary to meet the child's identified needs and how they can best be provided.
  - c. Coordination: Facilitating the child's access to the services and resources identified in the treatment plan, including:
    - (1) referral and follow-up services,
    - (2) arranging and attending case conferences, and
    - (3) arranging home visits, discharge, and aftercare services.
  - d. Other rehabilitative treatment services which in the opinion of the treatment coordinator are appropriate for inclusion in the individual treatment plan.
2. Living Skills Development: Client-centered activities directed at reducing mental disabilities of children in care, restoring them to their best possible functioning level, and assisting them in becoming responsible for their own actions.

SECTION IV - PROGRAM COVERAGE

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3. Counseling, Therapy, Consultation, and Assessments: Individual, group, or family counseling and therapy, consultation, psychological evaluations, or assessments necessary to improve or remedy personal problems or behaviors and to restore children to their best functioning level.
4. These services shall be provided by the DSS directly or through subcontact. Services may be provided at the following locations:
  - a. Private childcare;
  - b. Emergency shelters;
  - c. Maternity homes;
  - d. Group homes;
  - e. Therapeutic foster care or family treatment homes;
  - f. Day treatment; and
  - g. In the client's own home.

SECTION V - REIMBURSEMENT

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V. REIMBURSEMENT

A. Targeted Case Management Services

Payment shall be based on cost. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. Case Management providers who are public state agencies shall have on file an approved cost allocation plan.

A maximum of one (1) unit of case management services shall be reimbursed per month for each eligible recipient. A unit of case management is defined as at least one (1) telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the recipient receives or may receive services. All contacts shall be for the coordination or linkage of services for a specific recipient.

B. Rehabilitative Services

Payments shall be based on cost. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state health or Title V agency subcontracts with another state agency for the provision of services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

A maximum of one (1) unit of rehabilitative services shall be reimbursed per month for each eligible recipient with the cost of all rehabilitative services provided during the month included in the billable unit of service. A unit of rehabilitative service is defined as at least one (1) rehabilitative service provided to the recipient during the month.

**TITLE V SERVICES PROVIDED BY DSS**

**APPENDICES**

MAP-343 (Rev. 5/86)

Provider Number: \_\_\_\_\_  
(If Known)

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

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

\_\_\_\_\_  
**(Address of Provider)**

hereinafter referred to as the Provider.

**WITNESSETH, THAT:**

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

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

\_\_\_\_\_  
**(Type of Provider and/or level of care)**

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

**1. The Provider:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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



MAP-343 (Rev. 5/86)

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

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

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

**PROVIDER**

**CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES**

BY: \_\_\_\_\_  
Signature of Authorized Official

BY: \_\_\_\_\_  
Signature of Authorized Official

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

TITLE: \_\_\_\_\_

D A T E : \_\_\_\_\_

DATE: \_\_\_\_\_

MAP-344 (Rev. 8/93)

KENTUCKY MEDICAID PROGRAM

Provider Information

- 1. \_\_\_\_\_  
(Name) (County)
- 2. \_\_\_\_\_  
(Physical Location Address: Street, Route)
- 3. \_\_\_\_\_  
(City) (State) (Zip Code)
- 4. \_\_\_\_\_  
(Office Phone # of Provider) (Billing Office Phone # and Contact Person)
- 5. \_\_\_\_\_  
(Pay to Address, if Different From Physical Location)
- 6. \_\_\_\_\_  
(City) (State) (Zip Code)
- 7. \_\_\_\_\_ 8. \_\_\_\_\_  
(Federal Employee I.D. #) (Social Security #)
- 9. \_\_\_\_\_ 10. \_\_\_\_\_ 11. \_\_\_\_\_  
(License #) (Medicare #) (UPIN #)
- 12. \_\_\_\_\_ 13. \_\_\_\_\_  
(Licensing Board) (Original License Date)
- 14. \_\_\_\_\_ 15. \_\_\_\_\_ (Attached)  
(CLIA #) (Type of Certificate)
- 16. Physician/Professional Specialty Certification Board:  
\_\_\_\_\_  
1st \_\_\_\_\_ Date \_\_\_\_\_  
2nd \_\_\_\_\_ Date \_\_\_\_\_  
Attach Copy of Board Certification,
- 17. Federal DEA # and Date Assigned: \_\_\_\_\_

18. Practice Organization/Structure: \_\_\_\_\_ (1) Corporation  
\_\_\_\_\_ (2) Partnership \_\_\_\_\_ (3) Individual  
\_\_\_\_\_ (4) Sole Proprietor \_\_\_\_\_ (5) Public Service Corporation  
\_\_\_\_\_ (6) Estate/Trust \_\_\_\_\_ (7) Government/Non-Profit

19. If Corporation, list name and address of officers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Corporate Office Address) (Telephone #)

\_\_\_\_\_  
(City) (State) (Zip Code)

20. If partnership, list name and address of partners:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. If sole proprietor, give name, address, and phone number of owner:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. Control of Medical Facility:

\_\_\_\_\_ Federal \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ City  
\_\_\_\_\_ Charitable or Religious \_\_\_\_\_ Proprietary (Privately-Owned)  
\_\_\_\_\_ Other

23. If facility is government owned, list names and address of board members:

President/Chairman \_\_\_\_\_

Member: \_\_\_\_\_

Member: \_\_\_\_\_

24. Distribution of beds in facility:

Acute Care \_\_\_\_\_ Psychiatric \_\_\_\_\_ Swing \_\_\_\_\_

Nursing \_\_\_\_\_ MR/DD \_\_\_\_\_

25. Fiscal Year End: \_\_\_\_\_

26. Administrator: \_\_\_\_\_ Phone # \_\_\_\_\_

27. Assistant Administrator: \_\_\_\_\_ Phone # \_\_\_\_\_

28. Controller: \_\_\_\_\_ Phone # \_\_\_\_\_

29. Accountant or CPA: \_\_\_\_\_ Phone # \_\_\_\_\_

30. Management Firm: \_\_\_\_\_

31. Lessor: \_\_\_\_\_

32. Has this application been completed as the result of a change of ownership or a change of tax ID number for a previously enrolled Kentucky Medicaid provider?

\_\_\_\_ Yes      \_\_\_\_ No

If yes give previous Kentucky Medicaid provider #: \_\_\_\_\_

33. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Return all enrollment forms, changes, and inquiries to:

Medicaid-Provider Enrollment  
CHR Building, Third Floor East  
275 East Main Street  
Frankfort, KY 40621

INTER-OFFICE USE ONLY
License Number Verified through _____ (Enter Code)
Comments: _____
Date: _____ Staff: _____

MAP-380 (Rev. 04/90)

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES  
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electron&Media Addendum

This addendum to the Provider Agreement is made and entered into as of the \_\_\_ day of \_\_\_\_\_, 19\_\_\_ by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and \_\_\_\_\_,

Name and Address of Provider

hereinafter referred to as the Provider.

WITNESSETH, THAT:

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

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

\_\_\_\_\_  
(Type of Provider and/or Level of Care)

\_\_\_\_\_  
(Provider Number)

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

1. The Provider:

- A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.
- B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.
- C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

"This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

MAP-380 (Rev. 04/90)

Page 2

- D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.
- E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.
- F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force,
- G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

- A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.
- B. Agrees to assign to the provider or its agent a code to enable the media to be processed.
- C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

CABINET FOR HUMAN RESOURCES  
Department for Medicaid Services

BY: \_\_\_\_\_  
Signature of Provider

BY: \_\_\_\_\_  
Signature of Authorized Official  
or Designee

Contact Name: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Software Vendor  
and/or Billing Agency: \_\_\_\_\_

Media: \_\_\_\_\_

MAP-246 (Rev. 04/91)

Agreement Between the  
Kentucky Medicaid Program  
and  
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The \_\_\_\_\_ has  
(Name of Billing Agency)

entered into a contract with \_\_\_\_\_,  
(Name of Provider)  
\_\_\_\_\_, to submit claims via electronic media for services provided to  
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;
2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any **payment**, regardless of amount, knowing the same to be false, is subject to **civil and/or** criminal sanctions under-applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause. --

\_\_\_\_\_  
Signature, Authorized Agent of Billing Agency

Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Software Vendor  
and/or Billing Agency: \_\_\_\_\_

Media: \_\_\_\_\_

\_\_\_\_\_  
Signature, Representative of the  
Department for Medicaid Services

Date: \_\_\_\_\_



**CABINET FOR HEALTH SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

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**MEDICAID PROGRAM FISCAL AGENT INFORMATION**

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The Kentucky Department for Medicaid Services' fiscal agent, effective December 1, 1995, shall be the Unisys Corporation. Unisys may be reached as follows:

**UNISYS CORPORATION ADDRESSES**

**Accident & Work Related Claims  
Post Office Box 2107  
Frankfort, KY 40602**

**Prior Authorization  
Post Office Box 2103  
Frankfort, KY 40602**

**Adjustments & Claims Credits  
Post Office Box 2108  
Frankfort, KY 40602**

**Provider Relations (Inquiries)  
Post Office Box 2100  
Frankfort, KY 40602**

**Cash Refund  
Post Office Box 2108  
Frankfort, KY 40602**

**Third Party Liability  
Post Office Box 2107  
Frankfort, KY 40602**

**Claims Submission  
Post Office Box 2101  
Frankfort, KY 40602**

**Electronic Claims Submission  
Post Office Box 2016  
Frankfort, KY 40602**

**Unisys Corporation Telephone Numbers:**

**Kentucky**

**Drug Prior Authorization: 800-807-1273  
Electronic Claims: 800-205-4696  
Provider Relations: 800-807-1232**

**Out-of-State**

**Drug Prior Authorization: 502-226-1140  
Electronic Claims: 502-226-1140  
Provider Relations: 502-226-1140**

**Automated Voice Response System  
Claims Status Inquiries: 800-807-1301  
KenPAC Eligibility: 800-807-1301  
Third Party Liability Eligibility: 800-807-1301**