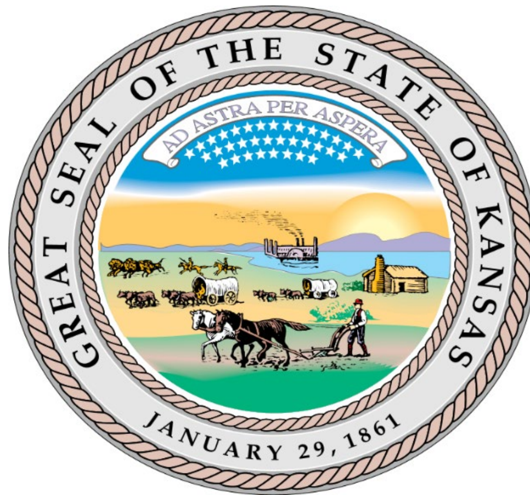


# Kansas Local Health Department Clinical Services Coding

*Resource Guide*

**<u>UPDATED: DECEMBER 2024</u>**

<u>**DISCLAIMER**: THIS MANUAL HAS BEEN A COLLABORATIVE EFFORT FROM NUMEROUS HEALTH DEPARTMENT BILLERS ACROSS THE STATE. THE INFORMATION CONTAINED IS PROVIDED ONLY AS A SUGGESTION OF POSSIBLE USE. MANY POLICIES, PROCEDURES AND CODES WILL VARY BASED ON INDIVIDUAL DEPARTMENTS, SERVICES OFFERED, AND INDIVIDUAL SITUATIONS.</u>

**<u>IT IS THE RESPONSIBILITY OF EVERY DEPARTMENT TO VERIFY INFORMATION AS IT PERTAINS TO THEIR OWN INDIVIDUAL DEPARTMENTS PRIOR TO USING THIS INFORMATION.</u>**

WICHITA STATE UNIVERSITY

COMMUNITY ENGAGEMENT INSTITUTE

*Center for Public Health Initiatives*

# PREFACE

The **Public Health Billing Resource Guide** provides policy & procedural guidance on how to bill 3rd party payers for public health programs and services. Developed as a billing resource tool; its purpose is to assist state, district, and county public health staff in understanding the insurance coding and billing process.

**Part I - Opportunities to Connect** provides options for networking with KDHE and LHD billing staff through listserv enrollment, attendance at regional billing meetings, and developing a network of contacts.

**Part II - The Policies and Procedures** section focuses on the terms and conditions of billing and reimbursement from 3rd party payers. It provides guidance on eligibility & verification, coordination of benefits and billing procedures to avoid delays in reimbursement.

**Part III - The Billing & Coding: Methodologies & Rates** section emphasizes the importance of the clinical components of CPT coding to ensure 3rd party payers are charged at the appropriate level of service delivery and reimbursement.

**Part IV - Appendices** section includes related links, contact information, acronyms, definitions, and other resources used in mastering the reimbursement process.

Amendments are made annually in accordance with policy changes in federal and state laws.

**Disclaimer:** Contract Provisions between LHD and 3rd Party Private Payers contain confidential and proprietary information that prohibits dissemination, distribution, or disclosure of reimbursement rates to any parties other than county Boards of Health and LHD employees.

Currently, KanCare is contracted with the following 3rd Party Payers as Managed Care Organizations (MCO):

- Healthy Blue
- Sunflower Health Plan
- United Healthcare Community Plan

Note: MediKan and Medicare are accepted for other services, i.e., Maternal and Child Health, Family Planning, Adult Health, etc. in most of our county health departments.

*Special thanks* to all the LHD billers and representatives of 3rd party payers who worked on the annual manual revisions and those who will contribute to future updates. This work would not have happened without you.

Any comments or suggestions for updates and changes to this manual can be emailed to your Regional Billing Group contact(s) or to Tina Payne (tina.payne@wichita.edu).

# Change Log

| Section | Update Notes |
|---|---|
| Cover | Date/version updated |
| Preface | Added Healthy Blue as the newly contracted MCO. |
| Opportunities to Connect (pages 8 & 9) | Updated maps: Kansas Regional Public Health; EHR Platforms Used by Local Health Departments from 2024 ATL Survey |
| Section 1.2 Medicaid Enrollment Process | Updated link to Provider Agreement and Choosing a KanCare Health Plan |
| Section 1.3 Medicare Enrollment Process | NEW - Added section on how LHD register as roster billers under their NPI number for the facility. |
| Section 1.4 Private Insurance Enrollment | Updated link for Aetna to private insurance company. |
| Section 2.2 Eligibility & Verification | Updated links: Program Fact Sheets and Eligibility for KanCare. |
| Section 3.4 Third Party Liability Noncovered | Added appeal information and recent General Bulletins. |
| Section 4.3 Filing Time Limits | Corrected Claims - Updated information for Aetna Better Health and added Healthy Blue.<br>Health Insurance Policy – Added Healthy Blue and corrected title of Aetna to indicate this is a private insurance plan. |
| Section 4.5 Medicaid Denial Issues | Added phone number for Healthy Blue.<br>Updated link to Frequently Asked Questions. |
| Section 4.6 MCO Reconsideration Process | Added information from General Bulletins 18039 and 21137. |
| Section 5.2 Eligibility Verification and Prior Authorizations | Prior Authorizations, Submit Service Referral, and Service Referral Search – included new links to the KMAP Provider Portal and Resource Guide for more information and forms. |
| Section 5.5 Interactive Tools – KMAP Reference Codes | EOB Crosswalk – Updated Link |
| Section 5.7 How to look up Maximum Reimbursement Rates for Public Health | New sentence from KDHE to stress the importance of checking reimbursement rates on a monthly basis. |
| Section 6.1 Immunization Methodologies | Updated link for Vaccines for Children program. |
| Section 6.3 Immunizations 18 yrs of age and younger | NEW - Added Meningococcal conjugate – MenACWY and MenB (Penbraya) codes and age guidance. |
| Section 6.4 Immunizations 19 years of age and older | NEW - Added Pneumococcal Conjugate, 21 Valent (PCV21-Capvaxive) codes and age guidance. |
| Section 6.7 Influenza Vaccine Products | Updated section for 2024-2025 season. |
| Section 6.8 COVID-19 Products | Updated section for 2024-2025 season. |

| | |
|---|---|
| Section 6.9 Respiratory Syncytial Virus (RSV) | Updated section for 2024-2025 season.<br><br>Added ICD-10 codes for pregnant women. |
| Section 7.2 Child Health Services | Updated CPT code for Dental Services performed by a LHD. |
| Section 7.4 Maternal & Infant | NEW - Doula section added with codes and General Bulletin link.<br>Tobacco Screening and Cessation section created & updated. |
| Section 7.5 KanCare Specific Kan Be Healthy Components | Updated narrative and added manuals for additional reference.<br>NEW - Hearing, paper screen code added.<br>NEW - Vision, instrument based for ages 0-3 yr, or who are unable to use a vision chart code added.<br>Topical Fluoride Varnish, limit 3 applications for dental and 3 applications for medical, per member codes added for ADA and CMS 1500 claim forms. |
| Section 7.6 Lactation Counseling | Updated section to include telemedicine. |
| Section 7.7 Elevated Blood Lead (EBL) | NEW - Added section for nursing education and additional options available to LHDs wanting to become |
| Section 8.2 Family Planning | Examinations - Note added to indicate CPT codes which begin with an “S” are for Medicaid/KanCare billing only.<br>Tobacco Screening and Cessation section titled & updated. |
| Section 9.1 Adult Health/Misc Services Methodologies | NEW - Section Added for Community Health Workers (CHW) including billable codes and reference to the appendix 11.12 for more information. |
| Section 10.1 Laboratory | NEW - Added Gonadotropin, chorionic (HCG); quantitative code. |
| Appendix 11.4 Related Links | CDC Immunization Schedules updated link.<br>Added Healthy Blue link.<br>United Healthcare updated link. |
| Appendix 11.6 Vaccine Guidance | Updated Vaccine Eligibility Flow Chart. |
| Appendix 11.7 Common EDI Payer ID’s | Added Healthy Blue EDI code and customer service number. |
| Appendix 11.10 LHD Kan-Be-Healthy Billing Reference Tool: KanCare Only | Updated links to Kan-Be-Healthy manual and Bright futures guide (page 81). |
| Appendix 11.11 Social Determinants of Health Z-Codes | Updated links to training and resources. |
| Appendix 11.12 Community Health Workers | NEW – Added appendix with certification and billing information. |

# TABLE OF CONTENTS


PREFACE 2

Change Log 3

PART I – OPPORTUNITIES TO CONNECT 8

KALHD Billing Listserv 8

Regional Billing Groups 8

Kansas Department of Health and Environment Regional Public Health Map and LHD Contacts 9

EHR Platforms Used by Local Health Departments from 2024 Aid-to-Local Survey 10

PART II - BILLING POLICIES & PROCEDURES 11

Section 1 – Provider Enrollment 11

1.1 Introduction 11

1.2 Medicaid Enrollment Process 11

1.3 Medicare Enrollment Process 11

1.4 Private Insurance Enrollment Process 12

Section 2 - Insurance Eligibility & Verification 13

2.1 Introduction 13

2.2 Eligibility & Verification 13

Section 3 - Coordination of Benefits 15

3.1 Introduction 15

3.2 Primary & Secondary Payers 15

3.3 Third Party Liability Payment 15

3.4 Third Party Liability Noncovered List (Blanket Denial) 16

Section 4 - Claim Submission / Resubmission 17

4.1 Introduction 17

4.2 Claim Requirements 17

4.3 Filing Time Limits 18

4.4 Appeals Process 19

4.5 Medicaid Denial Issues 20

4.6 MCO Reconsideration Process 20

Section 5 - Kansas Medical Assistance Program (KMAP) 21

5.1 Website Introduction 21

5.2 Eligibility Verification and Prior Authorizations 21

5.3 KanCare Claim Submission & Inquiry 21

5.4 Manuals, Forms and Bulletins 21
5.5 Interactive Tools - KMAP Reference Codes 22
5.6 KMAP Fee-for Service Provider Manual: General Benefits 22
5.7 How to look up Maximum Reimbursement Rates for Public Health Providers 22
PART III - METHODOLOGIES & COMMON LHD CODING 25
Section 6 – Immunization Services 25
6.1 Methodologies 25
6.2 Vaccine guidance for dual coverage 25
6.3 Immunizations 18 years of age and younger 27
6.4 Immunizations 19 years of age & older 28
6.5 Medicare Part B 29
6.6 Medicare Part D (TransactRx) 29
6.7 Influenza Vaccine Products 2024-2025 Season 30
6.8 COVID-19 Products 2024-2025 Season 30
6.9 Respiratory Syncytial Virus (RSV) Products 2024-2025 Season 31
6.10 International Travel (Commonly billed) 31
Section 7 - Maternal & Child Health Services 32
7.1 Methodologies 32
7.2 Child Health Visits 32
7.3 Children 's Intervention Services 33
7.4 Maternal & Infant 33
7.5 KanCare Specific Kan Be Healthy Components 35
7.6 Lactation Counseling 38
7.7 Elevated Blood Lead (EBL) Education 38
Section 8 - Women's Health Services 39
8.1 Methodologies 39
8.2 Family Planning 40
Section 9 - Adult Health / Miscellaneous Services 43
9.1 Methodologies 43
9.2 Adult Health – Preventative/STD/TB/Nutritional Counseling/MISC 44
9.3 Miscellaneous Services 45
Section 10 - Laboratory Services 46
10.1 Laboratory 46
10.2 CLIA Certification 47

PART IV - APPENDICES 48
11.1 Component Requirements for Office/Home Visits 48
11.2 Exclusions 52
11.3 Vaccine Route of Administration Codes 56
11.4 Related Links 57
11.5 Acronyms and Definitions 58
11.6 Vaccine Guidance (Private, VFC and CHIP) 69
11.7 Common EDI Payer ID's 70
11.8 Claim Examples 71
11.9 National Drug Code Conversion Table 78
11.10 Local Health Department Kan-Be-Healthy Billing Reference Tool: KanCare Only 79
11.11 Social Determinants of Health Z-Codes 83
11.12 Community Health Workers 87

# PART I – OPPORTUNITIES TO CONNECT

## KALHD Billing Listserv

KALHD moderates state-wide forums for billers to ask questions and receive assistance from one another. No question is too simple or too complex. Billers on the listserv range from first time billers to those with more than 20 years of experience. The following listserv options are available:

- Billing
- Home Health Billing
- Electronic Health Record and non-Electronic Health Record users (designate which platform is used)

If you are not subscribed to the Billing listserv but would like to be, send an email with your name, title, and county to billing-subscribe@lists.kalhd.org with a request to join. For all others, go to KALHD Groups and click on the "All Groups" tab to see the list of available options. Subscription requests can be entered on each group page.

Please remember when using the listserv, every email and every reply will go to the whole group. Please keep questions and answers direct and to the point. Please do not reply to the whole group with pleasantries or email unrequested answers. This is not meant to be a deterrent in participation, but for you to be considerate of the number of emails that we all must manage daily.

## Regional Billing Groups

Regional Billing Groups are designed to help billers connect to one another through regular in-person meetings. MCO and payer representatives can and should be invited to these meetings as well as other organizations and representatives who might be able to assist billers. These are self-run groups which will only continue if participation remains valid. Check with your regional contact below if you would like to receive invitations to these groups.

**North Central Region (Billing Biddies)**

- Contact(s): Tia Edwards, Saline County, edwardst@salinecountyks.gov 785-833-7351
  Jenny Lundine, Mitchell County, jlundine@mitchellcountyks.gov 785-738-5175

**Northeast Region (Perpetually Perplexed Pros)**

- Contact: Melinda McIntyre, Johnson County, Melinda.McIntyre@jocogov.org 913-477-8352

**Northwest Region (Billers Anonymous)**

- Contact: Kendra Glassman, Thomas County, kglassman@thomascountyks.gov 785-460-4596

**South Central Region (Mission Impossible)**

- Contact: Amanda Knight, Reno County, amanda.knight@renogov.org 620-259-8408

**Southeast Region (Billers 'R' Us)**

- Contact: Kendall Mason, SEK Multi-County Health Department, kendell@sekmchd.com 620-223-4464

**Southwest Region (KIPHS User Group)**

- Contact: Ashley Burns, Hodgeman County, abhghealthdept@hotmail.com 620-357-8736

# Kansas Regional Public Health Map

KDHE BCHS Local Health, 1000 SW Jackson, Suite 340, Topeka, KS 66612-1365

Updated November 16, 2024

https://www.kdhe.ks.gov/1801/Kansas-Regional-Public-Health-Map

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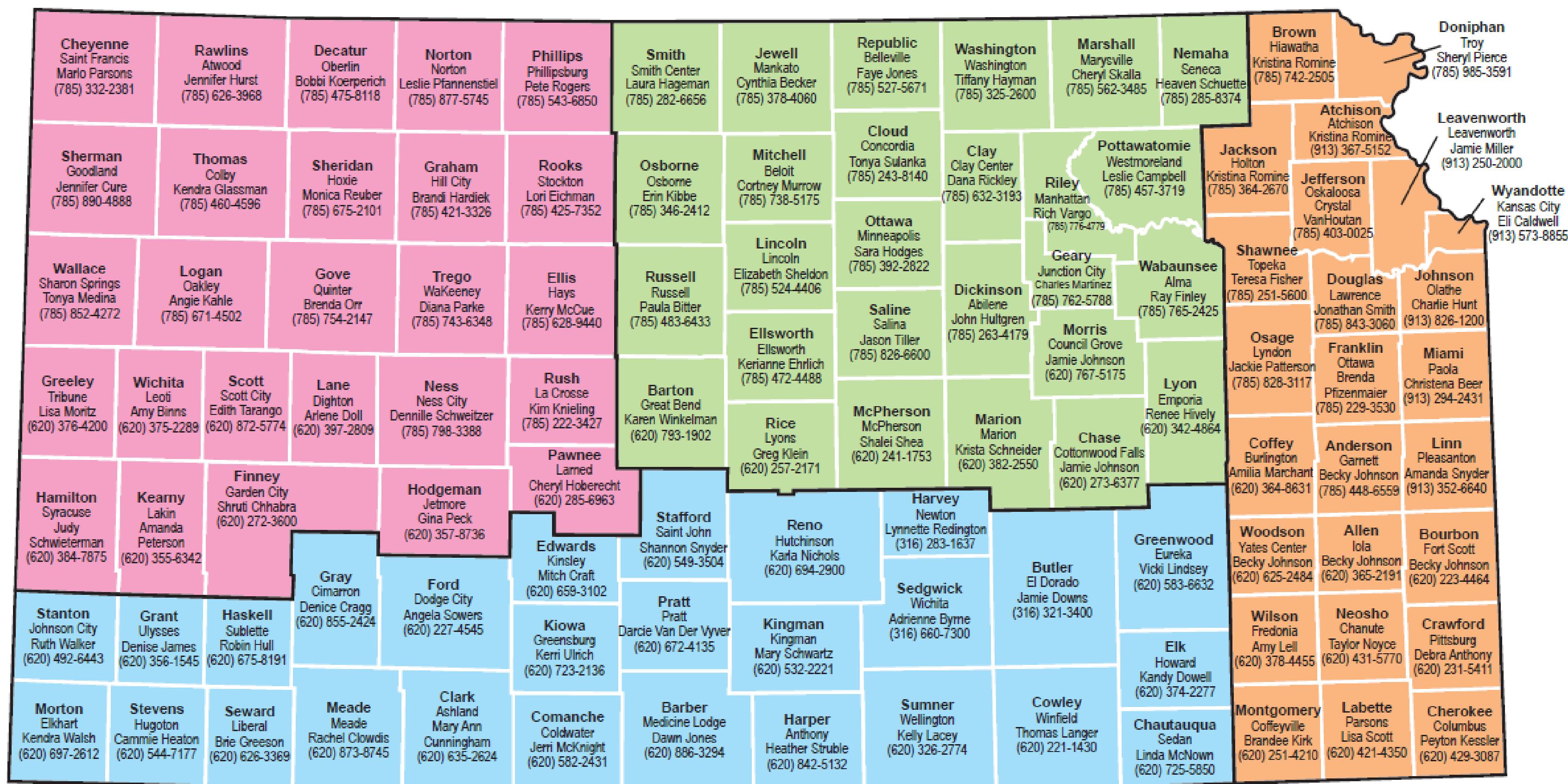


EHR Platforms Used by Local Health Departments from 2024 Aid-to-Local Survey

**Multi-County Health Departments** NEK: Atchison, Brown, Jackson SEK: Allen, Anderson, Bourbon, Woodson

Source: https://kphcollaborative.org/interactive-map/

# PART II - BILLING POLICIES & PROCEDURES

## Section 1 – Provider Enrollment

### 1.1 Introduction

Providers must be enrolled as a qualified provider with a 3rd party payer before they can submit claims for reimbursement. This section provides guidance on the Enrollment Process.

### 1.2 Medicaid Enrollment Process

A Kansas Medical Assistance Program (KMAP) Provider Agreement must be completed in order to participate in the Kansas Medical Assistance Program, found here: [ProviderHome](ProviderHome).

KMAP Enrollment/MCO Credentialing/MCO contracting process:

- Provider submits application for enrollment into the KMAP Provider Enrollment portal.
  - This will include all documents that the State of Kansas requires to enroll a provider into the KMAP program. KMAP Provider Enrollment does their best to collect required credentialing documents for the MCO's but that does not always occur.
- KMAP Provider Enrollment staff review all information and work with providers if the packet of documents submitted is incomplete for the purposes for KMAP Enrollment.
- Once KMAP Provider Enrollment has a complete packet of required documents the review is complete and provider is approved/disapproved for enrollment as a KMAP Provider.
- Providers must indicate on their application if information is to be shared with the MCO's and select each MCO information is to be shared with.
- Providers approved for KMAP enrollment will have information shared with the selected MCO's within 24-48 hours of the application.
- Local Health Departments contract with third-party payers as an ancillary facility and not as individual providers.

The State has selected three health plans, or managed care organizations (MCOs), to provide services to Medicaid consumers in the KanCare program. More information about each plan and how to contact them can be found at Choosing a KanCare Health Plan | KanCare.

Departments must enter into contracts with each MCO individually. KMAP enrollment is required before enrolling with a Medicaid MCO. Submitting an application or revalidating your existing application online, through the KMAP portal, will allow you to submit one application and select Fee for Service, Healthy Blue, Sunflower Health Plan and United Healthcare Community Plan. Once your application or revalidation has been approved your application will be sent via the Portal to the MCO(s) you selected, for that MCO to start their credentialing process.

### 1.3 Medicare Enrollment Process

Most Local Health Departments are considered roster billers with a National Provider Identifier (NPI) for the facility. Billing is primarily for administration of flu, pneumonia and covid.

For other services, the LHD would need to credential a provider, which includes a new enrollment process and fee with their license and NPI number. That provider would need their own PTAN number to bill.

Enrollment in Medicare should be completed by contacting WPS – Medicare B: WPS Government Health Administrators Home (wpsgha.com).

## 1.4 Private Insurance Enrollment Process

In order to bill most payers, the LHD must be contracted with the payer. It is best to contact each payer and ask how claims will be processed with and without a contract. Also an LHD may contract with a network. This allows the LHD to bill multiple payers under one contract. These are links in the PDF version of this manual.

| Payer | Private Insurances | Phone number | Website |
|---|---|---|---|
| BCBS | BCBS | 800-432-3587 | Professional Provider Home \| Blue Cross and Blue Shield of Kansas (bcbsks.com) |
| Aetna | Aetna | 800-624-0756 | Resources & Support for Health Care Providers \| Aetna |
| HPK | Network of insurances | 316-652-1327 | Provider resources \| Health Partners of Kansas (hpkansas.com) |
| ProviDr's | ProviDr's Care (WPPA) | 800-801-9772 | Providers - ProviDRs Care |
| WPS | WPS – Medicare B | 866-518-3285 | WPS Government Health Administrators Home (wpsgha.com) |
| Palmetto GBA | Railroad Medicare | 866-899-5227 | Railroad Providers (palmettogba.com) |

# Section 2 - Insurance Eligibility & Verification

## 2.1 Introduction

The business of Public Health begins with clients seeking services at local county health departments. This Section provides guidance on client intake and the steps required to obtain insurance information for billable services rendered in public health.

## 2.2 Eligibility & Verification

Frontline staff should brief clients on the intake process prior to receiving services. An effective intake process begins with a registration form that gathers vital information on the client's demographics, insurance coverage, and services requested. *New Patients* should complete a form at their first visit. Departments should set a policy to have *Established Patients* complete one at every visit or if they have any changes in their information since their last visit. Verifying and updating this information is critical at every visit.

Important Steps that should be taken with every client at every visit:

- Copy the client's primary and any secondary insurance cards
- Verify eligibility, policy status, effective date, type of plan and **Exclusions**
- Inform client of their responsibility for co-pays, coinsurances and deductibles
- Inform client of **Waiver** for non-covered services and payment options

It is to the benefit of the Provider to verify coverage **before** services are rendered. Failure to do so may result in non-payment of non-covered services and difficulties recouping payment from the client after services have been provided. "Active" coverage does not guarantee reimbursement for services listed on the Fee Schedule. Please refer to the client's individual Insurance Plan/Exclusions to identify "Non-Covered" services. Additional information regarding specific eligible members or program requirements can be found at Program Fact Sheets | KanCare.

In order to charge clients for non-covered services, a **Waiver for Non-Covered Services** with the following information must be provided to the client:

- Identify the service that is not covered
- Identify covered service that may be available in lieu of the non-covered service
- The cost of the service and payment arrangements
- The client must sign the Waiver indicating acceptance of the non-covered service and agreement to pay for the non-covered service

The beneficiary booklet and enrollment packet information for 2024 Member Open Enrollment is available at Choosing a Plan (ks.gov). Medicaid/KanCare eligibility can be verified at Eligibility | KanCare. This is a secure portal that requires a KMAP username and password.

**Beneficiary Responsibility:** The KMAP beneficiary can be held responsible for the payment of common services and situations. Beneficiaries may be billed only when program requirements have been met and the provider has informed the beneficiary in advance and in writing.

Suggested content for the Advance Beneficiary Notice (ABN): This constitutes advance notice to you, the beneficiary, that if all program requirements are met by (the provider) and payment is not made by Medicaid, you may be held responsible for the charges if your services are not covered by Medicaid. For services where there is normally no face-to-face contact between the beneficiary and the provider (examples are lab and radiology services), the written ABN signed annually by the beneficiary with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.

More information can be learned at ProviderManuals (kmap-state-ks.us) and selecting **General TPL Payment Manual** from the dropdown.

**Provider Discretion:** It is a Provider's discretion to accept a Medicaid/KanCare member as a client.

By accepting a Medicaid/KanCare member as a client, the Provider

1. Agrees to accept, as payment in full, the amount paid by Medicaid/KanCare for all covered services with the exception of co-pays and payments from 3rd party payers.
2. Is prohibited from choosing specific procedures for which the Provider will accept Medicaid/KanCare, whereby the Medicaid client would be required to pay for one type of covered service and Medicaid to pay for another service if applicable.

Failure to comply with these procedures will subject the Provider to sanctions, up to and including termination from the Medicaid/KanCare Program.

Some Departments will use procedures such as:

*When a client is ready to check-out, the pay station collects any copayments, deductibles, and service fees. Payment in full is expected at time of service. If a client is unable to pay, the clinical manager may make payment arrangements. The clinic manager should reinforce the Board of Health's or Health Department's billing policy and resolve the issue with the client through an agreed payment plan.*

# Section 3 - Coordination of Benefits

## 3.1 Introduction

By federal law, Medicaid is the "payer of last resort" in most circumstances. Coordination of Benefits (COB) is the process of determining the primary payer. This section will help define the "payer of last resort" status when submitting claims for payment. To find out more information on COB please refer to General TPL Payment Manual on the KMAP website.

## 3.2 Primary & Secondary Payers

Third-party liability (TPL) is often referred to as other insurance (OI), other health insurance (OHI), or other insurance coverage (OIC). Other insurance is considered a third-party resource for the beneficiary. Third-party resources can be health insurance (including Medicare), casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries.

The Kansas Medical Assistance Program (KMAP) is a secondary payer to all other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. The only exceptions to this policy are listed below:

- Children and Youth with Special Health Care Needs (CYSHCN) program
- Kansas Department for Children and Families (DCF), formerly SRS
- Indian Health Services (IHS)
- Crime Victim's Compensation
- Vaccine for Children Program

## 3.3 Third Party Liability Payment

Details for TPL billing can be found here: KMAP Provider Manuals. Select General TPL Payment from the *Current Manual Type* dropdown.

- The Provider's Role
- Billing Requirements
- Other Insurance Pricing
- Billing TPL after Receipt of KMAP Payment
- TPL Payment after Medicaid Payment
- No Response from Other Insurance
- Documentation Requirements
- Blanket Denials and Noncovered Codes

The following tips will assist Providers in reducing payment delays attributed to COB- related problems:

1. Ask All Patients about Secondary Insurance Coverage. Collect and confirm primary and secondary insurance information at each visit.
2. Know What Plans and Payers Need to Pay Claims. Nearly all plans require a copy of the Explanation of Benefits (EOB) from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting physician/provider representatives.
3. Primary & Secondary Payers: The following rules are used to determine the primary and secondary payer: a) The payer covering the patient as a subscriber will be the primary payer. b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule.

| WHAT IF…the Medicaid Member is also eligible for Medicare? | | |
|---|---|---|
| **SERVICE BY MEDICAID PROGRAM** | **MEDICARE** | **MEDICAID** |
| Health Check/Immunization | Does not Cover | Primary Payer |
| Family Planning | Does not Cover | Primary Payer |
| Perinatal Case Management/Pregnancy-Related Services | Does not Cover | Primary Payer |
| Dental Services (Health Check, Adult) | Does not Cover | Primary Payer |
| Adult Services/Immunizations | Primary Payer-Flu, Pneumonia, Hep B; MNT; Preventive Services | Secondary Payer |
| Nurse Practitioner/Physician Services | Primary Payer | Secondary Payer |

| WHAT IF…the Medicaid Member is also eligible for other private insurance coverage? | | |
|---|---|---|
| **SERVICE BY MEDICAID PROGRAM** | **PRIVATE INSURANCE** | **MEDICAID** |
| Health Check/Immunizations | N/A | Primary Payer |
| Perinatal Case Management/Pregnancy-Related Services | N/A | Primary Payer |
| Family Planning | COB REQUIRED | |
| Adult Services/Immunizations | COB REQUIRED | |
| Nurse Practitioner/Physician Services | COB REQUIRED | |
| Dental Services (Health Check, Adult) | COB REQUIRED | |

## 3.4 Third Party Liability Noncovered List (Blanket Denial)

When a service is not covered by a beneficiary's primary insurance plan, a blanket denial letter can be requested from the insurance carrier. The insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan covering the Medicaid beneficiary. The provider can also use a benefits booklet from the other insurance if it shows that the service is not covered. Providers can retain this statement on file to be used as proof of denial for one year. The noncovered status must be reconfirmed and a new letter obtained at the end of one year.

The most up-to-date TPL Noncovered List is located on KMAP and can be accessed here: KMAP Bulletin 16069 Third-Party Noncovered Procedure Code List dated 6/17/2016.

Appeal information on External Independent Third-Party Review by MCO's can be found here: 20015 - General - External_Independent_Third_Party_Review_UPDATED.pdf. Additional bulletins are available here: Bulletins.

# Section 4 - Claim Submission / Resubmission

## 4.1 Introduction

The Submission & Resubmission of Claims focuses on the importance of converting clinical services provided to a client into billable claims and submitting them via an Electronic Data Interchange to 3rd party payers for reimbursement. To receive proper payment for services, public health billing staff must collect accurate information required to submit a CMS 1500 insurance form correctly.

## 4.2 Claim Requirements

Providers must take all reasonable measures to determine a 3rd Party Payer's liability for covered services prior to filing a Medicaid claim. If a 3rd party insurance plan denies or pays insufficiently the applicable reimbursement rate:

- Attach proof of other insurance denial (an RA or letter of EOB from the insurer). Denials requesting additional information from the primary insurance company will not be accepted as proof of denial from the other insurance. If dates of service are over 12 months old, original timely filing must be proven as defined in Section 5100 of the General Billing Fee-for-Service Provider Manual. An original denial is only acceptable for the same service date(s) on the claim.
- When a Medicare supplemental plan (for example Plan 65) is the only other insurance applicable to the beneficiary and Medicare has denied payment on the claim, the provider is not required to submit the claim to the Medicare supplemental for denial. In this instance, the provider should resolve all denials through Medicare prior to billing the Medicare supplemental plan and Medicaid.
- When a carrier issues a blanket denial letter for a noncovered procedure code, the provider should include a copy of the denial and notate CARC code PR192 on the attachment. Refer to the Blanket Denials and Noncovered Codes portion of Section 3100 for documentation requirements (see section 3.3 of this manual).

For MCOs, failure to file a claim within the contracted timely filing after a service is rendered and/or failure to obtain a required prior approval or precertification will result in a denial of that claim. Obtaining prior approval or precertification does not guarantee payment of a claim.

If a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim. A 3rd Party Payer may deny part or all of a claim for the following reasons:

1. The services are not covered;
2. The client was not eligible on the date of service;
3. The provider failed to obtain prior approval or precertification for the required services; or,
4. The services provided have been determined to be medically unnecessary.

Federal law prohibits State payments for Medicaid services to anyone other than a provider, except in specified circumstances. Expressly prohibited are payments to collection agencies working on a percentage or other basis unrelated to the cost of processing the billing.

## 4.3 Filing Time Limits

Every health insurance company has its own policy on timely filing as part of each individual contract with providers. **Visit each payer site or contact a representative for details and updated information.**

| | |
|---|---|
| ***New Day Claims** | Generally, the timely filing requirement for new day claims is 180 days from the date of service |
| ***Corrected Claims** | The timely filing requirement for Aetna Better Health is 365 days from the date of service. Please note **December 31, 2024** is the final day services can be provided for an Aetna Better Health enrollee. |
| | Claim reconsideration for Healthy Blue must be submitted within 123 calendar days of the date on the Explanation of Payment (EOP). |
| | For Sunflower Health Plan, timely filing is 365 days from the notification of payment or denial (NOP). |
| | The timely filing requirement for United Healthcare Community Plan is 365 days from the date of service. |
| ***Claims impacted by Retro-eligibility** | Timely filing requirements begin on the date the member was deemed eligible by the state. A provider has 180 days from the date the member was determined eligible by the State to file their initial claim. |
| ** Providers must check their individual contract for each MCO for provider specific timely filing requirements. | |

| Health Insurance | Policy |
|---|---|
| Aetna Better Health | • Submission of claims: Standard timely filing is 180 days from the date of service. Please refer to your ABHKS Contract Agreement for specific requirements.<br>• Claim Reconsideration: 120 calendar days from the provider remittance advice/EOB.<br>• Formal Appeal: 60 calendar days from the last notice of adverse action (reconsideration notification letter, Notice of action letter) |
| Healthy Blue | • Submission of claims: Timely filing is within 180 calendar days from the date of service or per the terms of the provider contract.<br>• Claim reconsideration must be submitted within 123 calendar days of the date on the Explanation of Payment (EOP).<br>• Written appeals to Healthy Blue must be submitted within 63 calendar days of the Notice of Action (Examples: EOP or Notice of Action Reconsideration Resolution). |
| Sunflower Health Plan | • Submission: dependent on contract agreement. When Sunflower Health Plan is the secondary payer, claims must be received within 365 calendar days from date of the final determination of the primary payer.<br>• Resubmission: 180 calendar days from the original date of notification of payment or denial<br>• Appeals/Payment Disputes: 180 calendar days from the original date of notification of payment or denial. |
| United Healthcare Community Plan | • Submission of claims: Standard timely filing is 180 days from the date of service. Please refer to your UHC Participation Agreement for specific requirements.<br>• Claim Reconsideration: 120 calendar days from the provider remittance advice/EOB.<br>• Formal Appeal: 60 calendar days from the last notice of adverse action (reconsideration resolution, PRA, Notice of action letter) |
| Medicaid | • Submission: 12 months after the date of service.<br>• Appeals/Payment Disputes: 24 months after the date of service. |
| Medicare | • Submission: Claims must be received within 1 calendar year from the date of service.<br>• Appeals/Reconsiderations: Must be submitted within 6 months of the date on the notice of redetermination letter. |
| BCBS of Kansas | • Submission: 15 months from date of service.<br>• To submit a retrospective review online to Blue Cross Blue Shield of Kansas, go to: BCBSKS Provider Claim/Enrollment Inquiry Form<br>• Appeals/Payment Disputes: 120 days from the date of the RA for retrospective review; 60 days from the date of the retrospective review determination for appeals. |
| AETNA | • Submission: 120 days from date of service.<br>• Resubmission: 180 days from date of denial/processing<br>• Appeals/Payment Disputes: 180 days of the initial claim decision for reconsiderations; 60 days of previous decision for appeals |

## 4.4 Appeals Process

Every health insurance company has a grievance and appeal procedure defined in its policy. You can appeal a 3rd party payer's decision to deny a claim or pay less than the amount billed. Please refer to the appropriate payer's website for instructions on to appeal a claim.

The 3rd party payer may still deny a claim based on medical necessity despite pre-approval and a correctly coded claim. Appeal requests that do not contain sufficient information will not be processed.

## 4.5 Medicaid Denial Issues

When facing denials, there are multiple reasons that could be causing the issue. The first step in dealing with a denial is to review the denial code and determine what is causing the denial. Providers should work directly with their Medicaid MCO if there are questions or concerns regarding denials.

- Kansas KanCare Provider Number: 1-800-454-3730
- Healthy Blue Provider Services: 1-833-838-2595
- Sunflower Health Plan Provider Services Department: 1-877-644-4623
- United Healthcare Community Plan Provider Service: 1-877-542-9235
- Aetna Experience Department: 1-855-221-5656

Review prior claims or reach out for assistance from other billers. If you are still unsure of a correct course of action review the following website: Frequently Asked Questions | KanCare. This site contains a contact for KDHE. KDHE should be contacted only when all other resources have been exhausted.

## 4.6 MCO Reconsideration Process

Effective May 1, 2017 (updated March 5, 2018), KanCare providers will have the opportunity to dispute a denial of payment, in whole or in part, by a KanCare managed care organization (MCO) by submitting a Reconsideration and/or an Appeal to the MCO. Submission of a Reconsideration request is optional. The Reconsideration process offers providers an opportunity to submit a request to the MCOs to review a denial of payment prior to requesting an Appeal.

The Reconsideration process does not replace the Appeal process. Providers have the opportunity to submit an Appeal request to the MCO instead of submitting a Reconsideration request or after receipt of the Reconsideration resolution notice. A Reconsideration request must be submitted to the MCO no later than 120 calendar days from the date of the denial notice or Explanation of Payment (EOP). Once an MCO receives the Reconsideration request, it will review the payment denial and issue a Reconsideration resolution notice. A response to a reconsideration may not come in the form of a letter, it may come on a Remittance Advice. An Appeal request must be submitted to the MCO no later than 60 calendar days from the date of the denial notice or EOP or no later than 60 calendar days from the date of the Reconsideration resolution notice. An additional three calendar days from the date of the RA, EOP, or denial notice are added to the submission timeframes.

Completion of the Reconsideration process is not required prior to requesting an Appeal. Providers may terminate the Reconsideration process and file an Appeal within 60 calendar days of the date of the denial notice. Providers must complete the MCO's Appeal process prior to requesting a State Fair Hearing. Currently the MCOs have different processes for submitting a claim reconsideration. Refer to payer website for instructions.

Effective with claims processed on or after July 1, 2021, denials of payment involving non-clean claims will not be eligible for appeal rights with MCOs. This change affects only appeal rights for providers and does not change any claim processes MCOs currently have. A clean claim is defined as a claim that can be processes without obtaining additional information from the provider of the service or a third party. This includes claims with errors originating in the State's claims system and does not include a claim from a provider under investigation for fraud or abuse or is under review for medical necessity.

References: 17105_MCO_General.pdf; 18039 - MCO_General - Reconsideration.pdf; 21137 - General - Clean_Claims_and_Prov_Reconsiderations.pdf

# Section 5 - Kansas Medical Assistance Program (KMAP)

## 5.1 Website Introduction

The Kansas Medical Assistance Program (KMAP) website provides users with access to a variety of information such as eligibility verification, claim submission and inquiry, and prior authorizations. Visit Home (kmap-state-ks.us) for more information on enrollment. (Not all browsers are compatible with the KMAP website, and most of the current versions cause the site to be difficult to use. Try switching browsers or using an older version if the information is not displayed correctly. The website works best using internet explorer and adding the site to “compatibility view” under the tools menu.)

After logging in to the website, the mailbox view opens. Any recent changes will be listed here. These are official notifications and become part of your provider agreement. Any questions on KMAP specifics or issues in submitting claims can be discussed with a KMAP representative at 1-800-933-6593.

For those unfamiliar with submitting claims through KMAP, the Professional Billing Packet is the best place to start. The most current version can be found here: Provider Help Info (kmap-state-ks.us)

Below is an outline of the more frequently used resources available. These are links in the PDF version of this manual.

## 5.2 Eligibility Verification and Prior Authorizations

- Eligibility Verification: https://portal.kmap-state-ks.us/Eligibility/MainEligibilityVerification/
- Submit Prior Authorization Request: https://portal.kmap-state-ks.us/Authorization/SubmitMedical
- Prior Authorization Inquiry: https://portal.kmap-state-ks.us/Authorization/SearchAuthorizations
- For the following pages and additional information:
    - Prior Authorizations
    - Submit Service Referral
    - Service Referral Search

Go to:

- Online Help Site: KMAP Help Site
- KMAP Provider Portal Reference Guide (Version 5) Care Management Menu section (pg. 66) KMAP Provider Portal Reference Guide (.pdf)

## 5.3 KanCare Claim Submission & Inquiry

- Claim Submission
- Dental
- Institutional (Inpatient, Outpatient, Long Term Care and Medicare Cross-over)
- Professional
- Pharmacy
- Right to Appeal
- Claim Inquiry

## 5.4 Manuals, Forms and Bulletins

- ProviderManuals (kmap-state-ks.us)
- Forms (kmap-state-ks.us)
- Bulletins (kmap-state-ks.us)

## 5.5 Interactive Tools - KMAP Reference Codes

Pricing & Limitation information for Procedures, Diagnosis, Drugs, and Revenue Codes

- Reference Codes (kmap-state-ks.us)
- Search by Procedure
- Search by NDC
- Search by Diagnosis
- Coding Modifiers Table
- Ambulance Coding Modifiers Table
- Download Fee Schedules
- MS-DRG (Medicare Severity Diagnosis-Related Group) to CMS-DRG Crosswalk
- HCPCS Reference List
- Pharmacy Federal and State Pricing
- Fee Schedule for Outpatient Hospitals
- HCPCS Code Search
- EOB Crosswalk - Provider Help Info

## 5.6 KMAP Fee-for Service Provider Manual: General Benefits

When looking for Medicaid benefit details, the most current version of the "General Benefits" manual should be consulted. This is located in the *Provider Manual* link noted above, with a selection of "General Benefits." Below is an example of a key components of the 7/6/16 Manual that is regularly questioned.

*2700. DOCUMENTATION REQUIREMENTS Updated 10/15*

*Claim/Record Storage Requirements*

*K.S.A. 21-5931 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (This requirement includes primary care case management and lock-in referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.*

Providers who submit claims through computerized systems must maintain these records in a manner which is retrievable.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers:

- To keep such records as necessary to disclose fully the extent of services rendered to beneficiaries
- To furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider

Providing medical records to KDHE-DHCF or its designee is not a billable charge.

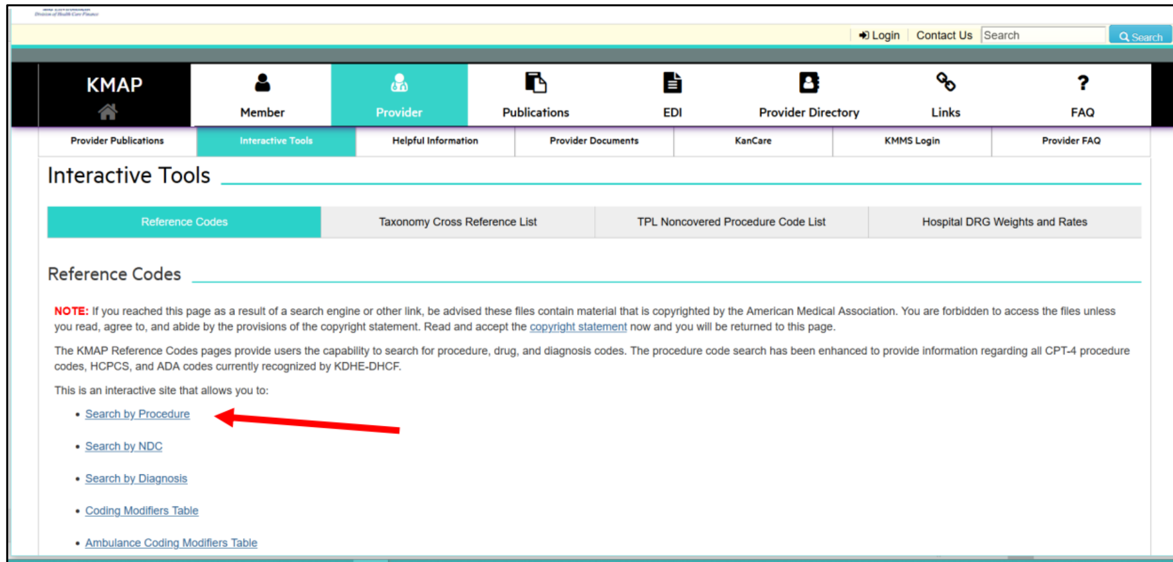
## 5.7 How to look up Maximum Reimbursement Rates for Public Health Providers

All information listed here is for reference and suggestions only. Please review all requirements for service and documentation prior to utilizing any listed CPT or ICD-10 codes. KMAP encourages LHDs to check the reimbursement rates on a monthly basis to be aware of the most current information.

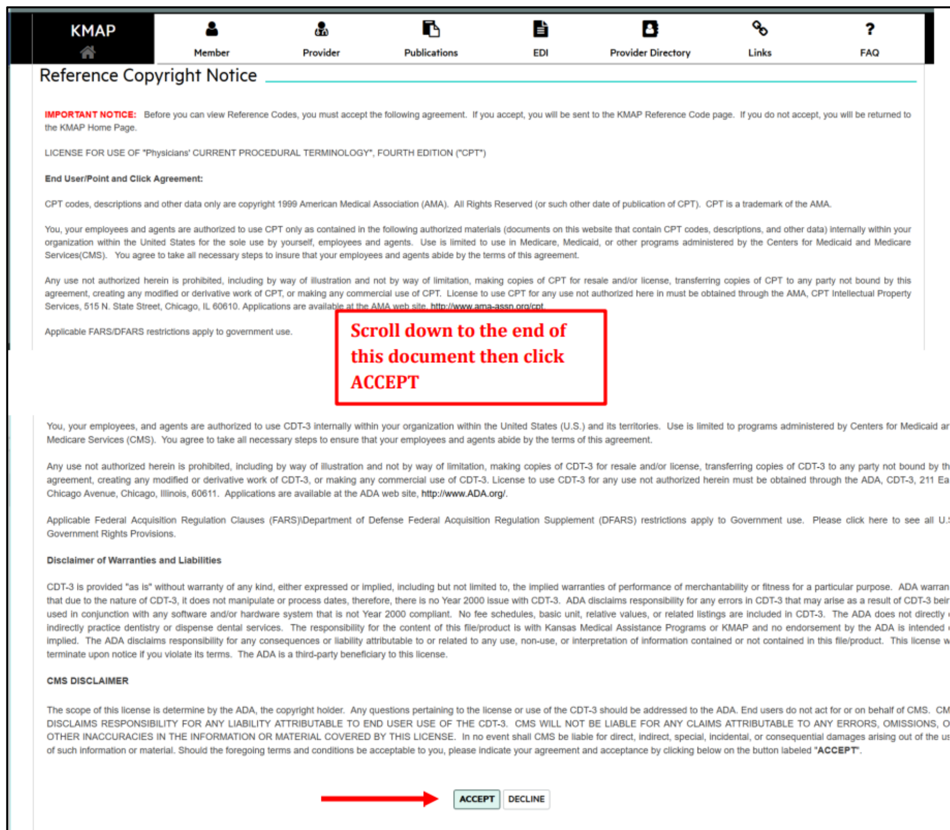
Per KMAP General Bulletin 16058 (April 2016), Kansas has adopted the Bright Futures/AAP Periodicity Schedule as a standard for pediatric preventive services through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs. For more information on Kan Be Healthy billing see the Bright Futures website or the AAP Manual Coding for Pediatric Preventive Care 2022.

To view current reimbursement rates:

1. Go to [Provider Interactive Tools (kmap-state-ks.us)]
2. Select **Search by Procedure**




3. Read the Copyright Notice and then click **ACCEPT**




4. Fill in all fields that have a blue asterisk then click **SEARCH**

KMAP | Member | Provider | Publications | EDI | Provider Directory | Links | FAQ

Search By Procedure (HCPCS Codes)

SEARCH CRITERIA

Information provided does not guarantee coverage or payment. Providers must reference provider manuals for specific coverage information or program limitations and verify if services are covered for their provider type and specialty and the member. All fields are required.

Disclaimer: Effective with dates of service on and after February 1, 2016, out-of-state and border city hospitals do not receive the adjustment factor/rate that is applied to "Outpatient Services – For Outpatient Hospital Claims (OPS)".

Disclaimer: Effective with the processing date of July 28, 2017, retroactive to dates of service on and after July 1, 2017, the previously implemented provider payment reduction was restored. Claims with a date of service prior to July 1, 2017, continue to receive the reduction. Effective for claims with DOS on and after 07/01/2018 the DRG adjustment percentage was increased to 78% for outliers (both cost outlier and day outlier).

| * HCPCS | * Date of Service | * Benefit Plan | Age |
|---|---|---|---|
| 90471 | 01/26/2023 | TXIX - TITLE XIX (MEDICAID) | |

| * Provider Type | * Provider Specialty | Modifier | Place of Service |
|---|---|---|---|
| 13 - Public Health Agency | 131 - Public Health or Welfare Agency a... | Select Modifier | Select Place Of Service |

RESET SEARCH

**Fill in information that has the asterisk then click SEARCH**

SEARCH RESULTS

# PART III - METHODOLOGIES & COMMON LHD CODING

## Section 6 – Immunization Services

### 6.1 Methodologies

The following guidance will allow for successful billing and maximum reimbursement of Immunization Services.

- Information on the Vaccine for Children Program - Eligibility Criteria for vaccines can be found at [About the Vaccines for Children (VFC) Program | VFC Program | CDC]
- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered. Reimbursements of CPT® codes for vaccines covered under the Vaccine for Children (VFC) program will not be allowed.
- Some software requires a charge on each line item being submitted. Known systems are KIPHS, Aetna Better Health of KS, and the UHC Community Plan. Providers need to indicate a charge, usually either $.01 or $1.00, on the line for the vaccine/toxoid code, even if they are not expecting to receive payment for services provided. Claims submitted with a negative or zero charged amount will be returned or rejected to the provider. Some LHD's bill the vaccine codes with the monetary amount to all three MCOs to maintain consistency. The system should deny the service even though a charge was submitted, although periodically the MCO's will inadvertently pay the vaccine code.
- As of October 29, 2010, administration of Vaccine for Children vaccines is exempt from third-party liability (TPL). When they are billed with an appropriate administrative code, providers do not have to bill the claim to the TPL carrier before Medicaid will process the claim for payment.
- Modifier 25 should be attached to the E/M service code if vaccines are administered during the same visit. Check with payer for specifics.
- Beginning in January 2022, BCBS of Kansas will have changes to their requirements for Qualifier codes. Providers will need to include the referring/ordering qualifier and NPI listed in box 17 of the 1500 Claim Form. For Health Departments without a MD/DO on-site, report the NPI of the doctor overseeing the Health Department.
- Qualifier Codes: Any claim with a laboratory service (8XXXX), diagnostic/immunization/vaccination/administration (9XXXX), or HCPC (excluding Ambulance) will require an ordering/referring provider name and NPI in addition to the appropriate qualifier for box 17 of the 1500 Claim Form.
  - The Qualifiers for use in box 17 are:
    - DN, referring provider
    - DK, ordering provide
    - DQ, supervising provider
  - The NPI of the referring, ordering or supervising provider should be entered in field 17b.

### 6.2 Vaccine guidance for dual coverage

If a CHIP (T21) child has both private insurance and T21 what vaccine do you use?

Use private vaccine and bill the insurance company for the vaccine and administration fee. If CHIP vaccine is used by mistake, bill the private insurance company for the vaccine administration charge only. It is best to determine the child's coverage for immunizations before the service is provided this way you can use the correct vaccine funding source. If the child's private insurance does not cover vaccine, the child is CHIP eligible and CHIP vaccine is used. Be sure to keep this documentation in the child permanent record. This is important to avoid denials of claims and to help your clinic and the CHIP program to be sure the correct payer is billed for immunization services. If you receive a denial from the private

insurer and you determined the child had immunization coverage, please contact CHIP customer service 1-800-766-9012 for assistance.

This explanation was published in the FAQ document from KIP updated 3/4/14.

If a child has private insurance and T19 is secondary what vaccine funding source do I use and who is billed? Resource is from the 2015 CDC VFC Program Operation Guide page 29.

**INSURED EXCEPTIONS**

AI/AN with Health Insurance that Covers Immunizations:

AI/AN children are always VFC-eligible. VFC is an entitlement program and participation is not mandatory for an eligible child. For AI/AN children that have full immunization benefits through a primary private insurer, the decision to participate in the VFC program should be made based on what is most cost beneficial to the child and family.

Insured and Medicaid as Secondary Insurance:

Situations occur where children may have private health insurance and Medicaid (T19) as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid (T19). However, the parent is not required to participate in the VFC program. There are options for the parent and provider. These options are described below:

## Option 1

A provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee. In most healthcare situations, Medicaid is considered the "payer of last resort." This means that claims must be filed to and rejected by all other insurers before the Medicaid agency will consider payment for the service. This is not true of the VFC vaccine administration fee for Medicaid-eligible children. The Medicaid program must pay the VFC administration fee because immunizations are a component of the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. However, once the claim is submitted to Medicaid, the state Medicaid agency does have the option to seek reimbursement for the administration fee from the primary insurer.

Please note: If the state Medicaid agency rejects a claim for a vaccine administration fee for a child with Medicaid as secondary insurance, stating the claim must first be submitted to the primary insurer for payment, the provider should notify the awardee (KIP). The awardee (KIP) should notify their CDC project officer so that CDC can work with CMS to educate the state Medicaid agency and correct the situation.

Considerations regarding this option:

- This is the easiest way for a provider to use VFC vaccine and bill Medicaid for the administration fee.
- There are no out-of-pocket costs to the parent or guardian for the vaccine or the administration fee.

## Option 2

A provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee. If the primary insurer pays less than the Medicaid amount for the vaccine administration fee, the provider can bill Medicaid for the balance of the vaccine administration fee, up to the amount Medicaid pays for the administration fee. If the primary insurer denies payment of vaccine and the administration fee, the provider may replace the privately purchased vaccine with VFC vaccine and bill Medicaid for the administration fee. The provider must document this replacement on the VFC borrowing form (see Module 4).

Considerations regarding this option:

- The provider may be reimbursed a higher amount if privately purchased vaccine is administered and both the vaccine and the administration fee are billed to the primary insurer.
- The provider should choose from the vaccine inventory that is most cost-effective for the family.
- The parent/guardian of a child with Medicaid as secondary insurance should never be billed for a vaccine or an administration fee.

## 6.3 Immunizations 18 years of age and younger

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| **Vaccine Administration** | | | |
| Imm admin, with counseling; 1st or only component | 90460 | Z23 | 0 -18 yrs |
| Imm admin, with counseling; ea additional component<br>+ add on code* (not Payable through KanCare) | 90461 | Z23 | 0 -18 yrs |
| Immunization admin; 1 vaccine | 90471 | Z23 | |
| Immunization admin; each additional vaccine<br>+ add on code* | 90472 | Z23 | |
| Immunization admin, oral, nasal; 1 vaccine | 90473 | Z23 | |
| Immunization admin, oral, nasal; each additional vaccine<br>+ add on code* | 90474 | Z23 | |
| **Vaccines – Private and VFC** | | | |
| DTaP, Diphtheria, Tetanus, Pertussis (Daptacel, Tripedia) | 90700 | Z23 | 0 – 6yrs |
| DTaP-Hep B-IPV (Pediarix) | 90723 | Z23 | |
| DTaP-HIB-IPV (Pentacel) | 90698 | Z23 | |
| DTaP-IPV (Kinrix) | 90696 | Z23 | 4 yrs – 6 yrs |
| DTaP-IPV-Hep B-HIB (Vaxelis) | 90697 | Z23 | |
| Hep A, 2-dose, (Havrix,Vaqta) | 90633 | Z23 | 1yr – 18 yrs |
| Hep A, 3-dose, (Havrix) | 90634 | Z23 | 1yr – 18 yrs |
| Hep B, 3-dose (Engerix-B) | 90744 | Z23 | |
| Hep A-Hep B, (Twinrix) | 90636 | Z23 | 18 yrs |
| HIB, Hemophilus b, 3-dose (PedvaxHib) | 90647 | Z23 | |
| HIB, Hemophilus b, 4-dose, (Acthib,Hiberix) | 90648 | Z23 | |
| HPV, types 6, 11, 16, 18, 31, 33, 45, 52, 58 (Gardasil) | 90651 | Z23 | |
| IPV, Polio (IPOL) | 90713 | Z23 | |
| Meningococcal conjugate (Menactra, Menveo) | 90734 | Z23 | |
| Meningococcal conjugate (MenQuadfi) | 90619 | Z23 | 2 yrs – 18 yrs |
| Meningococcal Group B (Bexsero) | 90620 | Z23 | |
| Meningococcal conjugate - MenACWY and MenB (Penbraya) | 90623 | Z23 | At Risk – 10 yrs – 15 yrs |
| MMR, Measles, Mumps, Rubella (Priorix) | 90707 | Z23 | |
| MMRV, Measles, Mumps, Rubella, Varicella (ProQuad) | 90710 | Z23 | |
| Pneumococcal, 13 valent (Prevnar 13) | 90670 | Z23 | |
| Pneumococcal, 15 (Vaxneuvance) | 90671 | Z23 | |
| Pneumococcal, 20 valent (PCV20) | 90677 | Z23 | 2 yrs – 18 yrs |
| Pneumococcal, 23 valent (Pneumovax 23) | 90732 | Z23 | 2 yrs & 18 yrs |
| Rotavirus, 2-dose, live, oral (Rotarix) | 90681 | Z23 | |
| Rotavirus, 3-dose, live, oral (RotaTeq) | 90680 | Z23 | |
| Td, Tetanus, Diphtheria toxoid, preservative free (Tenivac) | 90714 | Z23 | 7 yrs & 18 yrs |
| Tdap, Tetanus, Diphtheria & Pertussis (Boostrix, Adacel) | 90715 | Z23 | 7 yrs & 18 yrs |
| Varicella, live (Varivax) | 90716 | Z23 | |
| *+ add on codes: codes that are always performed in addition to the primary service or procedure & must never be reported as a stand-alone-code. | | | |

## 6.4 Immunizations 19 years of age & older

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| **Vaccine Administration** | | | |
| Immunization admin; 1 vaccine | 90471 | Z23 | |
| Immunization admin; each additional vaccine<br>+ add on code* | 90472 | Z23 | |
| Immunization admin, oral, nasal; 1 vaccine | 90473 | Z23 | |
| Immunization admin, oral, nasal; each additional vaccine<br>+ add on code* | 90474 | Z23 | W<br>W |
| **Vaccines** | | | |
| DT, Diphtheria, Tetanus toxoid | 90702 | Z23 | |
| Hep A 2-dose (Vaqta, Havrix) | 90632 | Z23 | |
| Hep A-Hep B, adult (Twinrix) | 90636 | Z23 | |
| Hep B (Recombivax) Pediatric/adolescent dose | 90744 | Z23 | 19 years only |
| Hep B (Engerix-B) | 90746 | Z23 | |
| Hep B, dialysis or Immunosuppressed | 90740 | Z23 | |
| HPV, types 6, 11, 16, 18, 31, 33, 45, 52, 58 (Gardasil) | 90651 | Z23 | |
| IPV, Polio (IPOL) | 90713 | Z23 | |
| Meningococcal conjugate (Menactra, Menveo) | 90734 | Z23 | |
| Meningococcal conjugate (MenQuadfi) | 90619 | Z23 | |
| Meningococcal Group B (Bexsero) | 90620 | Z23 | |
| MMR, Measles, Mumps, Rubella (Priorix) | 90707 | Z23 | |
| MMRV, Measles, Mumps, Rubella, Varicella (ProQuad) | 90710 | Z23 | |
| Pneumococcal, 13 Valent (Prevnar 13) | 90670 | Z23 | |
| Pneumococcal, 15 (Vaxneuvance) | 90671 | Z23 | |
| Pneumococcal, 20 Valent (Prevnar 20) | 90677 | Z23 | |
| Pneumococcal Conjugate, 21 Valent (PCV21 - Capvaxive) | 90684 | Z23 | Age 65 and older covered<br>Age 19-64 with risk factors |
| Pneumococcal 23-Valent (Pneumovax 23) | 90732 | Z23 | |
| Shingrix | 90750 | Z23 | 50 years & older covered |
| Td, Tetanus, Diphtheria toxoid, preservative free (Tenivac) | 90714 | Z23 | |
| Tdap, Tetanus, Diphtheria & Pertussis (Boostrix, Adacel) | 90715 | Z23 | |
| Varicella, live (Varivax) | 90716 | Z23 | |
| *+ add on codes: codes that are always performed in addition to the primary service or procedure & must never be reported as a stand-alone-code. | | | |

## 6.5 Medicare Part B

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| **Vaccine Administration** | | | |
| Immunization; Influenza | G0008 | Z23 | |
| Immunization; Pneumococcal | G0009 | Z23 | |
| Influenza & Pneumococcal billed together | G0008,G0009 | Z23 | |
| **Vaccines** | | | |
| Pneumococcal, 13 Valent (Prevnar 13) | 90670 | Z23 | |
| Pneumococcal, 15 (Vaxeuvance) | 90671 | Z23 | |
| Pneumococcal, 20 Valent (Prevnar 20) | 90677 | Z23 | |
| Pneumococcal 23-Valent (Pneumovax 23) | 90732 | Z23 | |

## 6.6 Medicare Part D (TransactRx)

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| **Vaccine Administration** | | | |
| Immunization admin; 1 vaccine | 90471 | Z23 | |
| Immunization admin; each additional vaccine + add on code* | 90472 | Z23 | |
| **Vaccines – commonly billed** | | | |
| Hep A, (Havrix) .5 ml syringe | 90633 | Z23 | 1yr – 18 yrs |
| Hep A, (Havrix) 1ml syringe or vial | 90632 | Z23 | 18 yrs + |
| Hep A, (Vaqta) 1ml vial | 90632 | Z23 | 18 yrs + |
| Hep B, (Engerix-B) 20mcg ml syringe or vial | 90746 | Z23 | 18 yrs + |
| Hep A/HepB, 1ml syringe or vial | 90636 | Z23 | 18 yrs + |
| HPV, types 16,18, (Cervarix) .5ml syringe or vial | 90650 | Z23 | |
| Meningitis, (Menactra) .5ml syringe or vial | 90734 | Z23 | |
| Meningitis, (MenQuadfi) A/C/W/Y for intramuscular use | 90619 | Z23 | |
| Meningitis, (Menveo) .5ml vial | 90734 | Z23 | |
| MMR, Measles, Mumps, Rubella (Priorix) | 90707 | Z23 | |
| Shingrix, vial | 90750 | Z23 | 50 yrs + |
| Td, (Tenivac) .5ml syringe or vial | 90714 | Z23 | 7 yrs + |
| Tdap, (Adacel) .5ml syringe or vial | 90715 | Z23 | 7 yrs + |
| Tdap, (Boostrix) .5ml syringe or vial | 90715 | Z23 | 7 yrs + |
| Varicella, (Varivax) .5ml vial | 90716 | Z23 | |

*+ add on codes: codes that are always performed in addition to the primary service or procedure & must *never* be reported as a stand-alone-code.

## 6.7 Influenza Vaccine Products 2024-2025 Season

Visit Flu Shot | CMS for additional Medicare and Medicaid Payment Allowance information.

| Manufacturer | Trade Name | Supply | Age Group | CPT | ICD-10 |
|---|---|---|---|---|---|
| AstraZeneca | FluMist (LAIV3) | 0.2 mL (single-use nasal spray) | 2 through 49 years | 90660 | Z23 |
| GSK | Fluarix (IIV3) | 0.5 mL (single-dose syringe) | 6 months & older | 90656 | Z23 |
| | FluLaval (IIV3) | 0.5 mL (single-dose syringe) | 6 months & older | 90656 | Z23 |
| Sanofi | Flublok (RIV3) | 0.5 mL (single-dose syringe) | 18 years & older | 90673 | Z23 |
| | Fluzone (IIV3) | 0.5 mL (single-dose syringe) | 6 months & older | 90656 | Z23 |
| | | 0.5 mL (single-dose vial) | 6 months & older | 90656 | Z23 |
| | | 5.0 mL multi-dose vial (0.25 mL dose) | 6 through 35 months | 90657 | Z23 |
| | | 5.0 mL multi-dose vial (0.5 mL dose) | 6 months & older | 90658 | Z23 |
| | Fluzone High-Dose (HD-IIV3) | 0.5 mL (single-dose syringe) | 65 years & older | 90662 | Z23 |
| Seqirus | Afluria (IIV3) | 5.0 mL multi-dose vial (0.25 mL dose) | 6 through 35 months | 90657 | Z23 |
| | | 5.0 mL multi-dose vial (0.5 mL dose) | 3 years & older | 90658 | Z23 |
| | | 0.5 mL (single-dose syringe) | 3 years & older | 90686 | Z23 |
| | Fluad (allV3) | 0.5 mL (single-dose syringe) | 65 years & older | 90653 | Z23 |
| | Flucelvax (ccIIV3) | 0.5 mL (single-dose syringe) | 6 months & older | 90661 | Z23 |
| | | 5.0 mL multi-dose vial (0.5 mL dose) | 6 months & older | 90661 | Z23 |
| Source: www.immunize.org/catg.d/p4072.pdf | | | | | |

## 6.8 COVID-19 Products 2024-2025 Season

| Manufacturer | Trade Name | Supply | Age Group | CPT | ICD-10 |
|---|---|---|---|---|---|
| Administration | | Administration fee | All Ages | 90480 | Z23 |
| Administration | | Home Based service | All Ages | M0201 | Z23 |
| Pfizer | SARS-CoV-2 | 0.2 mL dosage | 6 months through 4 years | 91318 | Z23 |
| | SARS-CoV-2 | 0.2 mL dosage | 5 years through 11 years | 91319 | Z23 |
| | SARS-CoV-2 | 0.3 mL dosage | 12 years & older | 91320 | Z23 |
| Moderna | SARS-CoV-2 | 0.25 mL dosage | 6 months through 11 years | 91321 | Z23 |
| | SARS-CoV-2 | 0.5 mL dosage | 12 years & older | 91322 | Z23 |
| Novavax | SARS-CoV-2 | 0.5 mL dosage | 12 years & older | 91304 | Z23 |
| Source: www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing | | | | | |

## 6.9 Respiratory Syncytial Virus (RSV) Products 2024-2025 Season

| Administration Codes | | | | | |
|---|---|---|---|---|---|
| Administrative Fee | | Abrysvo<br>Arexvy | | 90471 | |
| Administrative Fee | | Beyfortus (with counseling) | | 96380 | |
| Administration Fee | | Beyfortus (no counseling) | | 96381 | |
| **Manufacturer** | **Trade Name** | **Supply** | **Age Group** | **CPT** | **ICD-10** |
| Pfizer | Abrysvo | 0.5 mL vial | Pregnant women Ages 9 - 55<br>All – Ages 60 and over | 90678 | Z23 |
| GSK | Arexvy | 0.5 mL vial | At Risk – Ages 50-59<br>All - 60 and over | 90679 | Z23 |
| Sanofi | Beyfortus | 0.5 mL syringe | All - Birth – 8 months<br>At Risk - Ages 8 to 19 months | 90380 | Z29.11 |
| | Beyfortus | 1.0 mL syringe | All - Birth – 8 months<br>At Risk - Ages 8 to 19 months | 90381 | Z29.11 |
| For additional information on age groups and delivery, see recommendations from manufacturers. | | | | | |

NOTES:

- Beyfortus vaccine has been approved for reimbursement through VFC but only for the administrative cost of the vaccine.
- When giving RSV to pregnant patient, per the KMAP policy, one of these diagnoses must be specified on the claim to indicate that the patient is pregnant:
    - Z3A.29 - Weeks of gestation of pregnancy, weeks 30-39,
    - Z3A.32 - 32 weeks gestation of pregnancy
    - Z3A.33 - 33 weeks gestation of pregnancy
    - Z3A.34 - 34 weeks gestation of pregnancy
    - Z3A.35 - 35 weeks gestation of pregnancy
    - Z3A.36 - 36 weeks gestation of pregnancy

## 6.10 International Travel (Commonly billed)

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| **Vaccine** | | | |
| Typhoid, injection | 90691 | Z23 | |
| Typhoid, oral | 90690 | Z23 | |
| Yellow Fever | 90717 | Z23 | |
| **Additional Vaccines per CDC Recommendations | | | |
| Medicaid and the MCOs do not cover Typhoid and Yellow Fever | | | |

# Section 7 - Maternal & Child Health Services

## 7.1 Methodologies

This section includes information on a variety of services which can be offered by an LHD. The section on KanCare Specific KAN Be Healthy screenings includes additional information on the program components and reimbursement requirements.

## 7.2 Child Health Visits

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| **Preventive** | | |
| New Patient: 1 day - 11 months | 99381 | Z00.121 Z00.129 |
| New Patient: 1 year - 4 years | 99382 | Z00.121 Z00.129 |
| New Patient: 5 years - 11 years | 99383 | Z00.121 Z00.129 |
| New Patient: 12 years - 17 years | 99384 | Z00.121 Z00.129 |
| New Patient: 18 years - 20 years | 99385 | Z00.00 Z00.01 |
| Established Patient: 1 day - 11 months | 99391 | Z00.121 Z00.129 |
| Established Patient: 1 year - 4 years | 99392 | Z00.121 Z00.129 |
| Established Patient: 5 years - 11years | 99393 | Z00.121 Z00.129 |
| Established Patient: 12 years - 17 years | 99394 | Z00.121 Z00.129 |
| Established Patient: 18 years - 20 years | 99395 | Z00.00 Z00.01 |
| **Evaluation & Management** | | |
| Nurse Visit | 99211 | |
| Nurse Visit/Assessment – KanCare Only | T1001 | |
| New Patient: Straight forward/minimal (15-29 minutes of total time) | 99202 | |
| New Patient: Low (30-44 minutes of total time) | 99203 | |
| New Patient: Moderate (45-59 minutes of total time) | 99204 | |
| New Patient: High (60-74 minutes of total time) | 99205 | |
| Established Patient: Straight forward/minimal (10-19 minutes of total time) | 99212 | |
| Established Patient: Low (20-29 minutes of total time) | 99213 | |
| Established Patient: Moderate (30-39 minutes of total time) | 99214 | |
| Established Patient: High (40-54 minutes of total time) | 99215 | |
| **Development/Audiology/Vision Screenings** | | |
| Developmental screening with interpretation and report | 96110 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, pure tone, air only | 92551 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, pure tone audiometry; air only | 92552 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, pure tone audiometry; air and bone | 92553 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, speech threshold | 92555 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, speech threshold; with speech recognition | 92556 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, comprehensive evaluation & speech recognition (92553,92556) | 92557 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Tympanometry (impedance testing) | 92567 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Acoustic reflex testing, threshold | 92568 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Conditioning play audiometry | 92582 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Evoked response (EEG) audiometry | 92585 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Automated Auditory Brainstem Response | 92586 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Evoked Otoacoustic Emissions; limited | 92587 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Vision, bilateral | 99173 | Z00.121, Z00.129 Z00.00, Z00.01 |

| Dental Services | | |
|---|---|---|
| Topical Fluoride Varnish (CMS 1500 claim form) | 99188 | Z01.20 Z01.21 |

## 7.3 Children 's Intervention Services

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| **Nutrition Services** | | |
| Nutrition Assessment; initial assessment, each 15 mins | 97802 | Z71.3 |
| Nutrition Assessment; re-assessment, each 15 mins | 97803 | Z71.3 |

## 7.4 Maternal & Infant

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| **Nurse Assessment-Mother** | | |
| Prenatal, 1 visit (maximum of 3) | H1000 | Z34.80 |
| Prenatal risk reduction | H1000 | Z34.90 |
| Prenatal, total package of 3 visits | H1005 | Z34.80 |
| Rhogham | 90384 | Z41.8 |
| Postpartum | T1001 | Z39.2 |
| **Infant Services-Infant** | | |
| Newborn – 0-28 days | 99502 | Z76.2 |
| Infant – over 28 days | T1001 | |
| **Nutrition Assessment** | | |
| Prenatal/Postpartum | S9470 | |
| **Social Work Assessment-Mother only** | | |
| Prenatal/Postpartum | H1002 | |
| **Antepartum Care - Qualified Healthcare Professional (APRN, ARNP, PA, MD)** | | |
| 1 – 3 visits, see appropriate E/M code(s) | 99211-99215 | Z34.80 |
| 4 - 6 visits | 59425 | Z34.80 |
| 7 or more visits | 59426 | Z34.80 |
| **Doula** | | |
| Prenatal Visits, 28 (15 minute units) | T1032 | Z33.1 |
| Attendance at Labor and Delivery (1 visit) | T1033 | Z33.1 |
| Postpartum Visits, 25 (15-minute units) | T1032TS | Z39.2 |
| *For More Information:* [24099 - General - Doulas_Enrollment_and_Coverage.pdf]() | | |
| **Tobacco Screening and Cessation** | | |
| Smoking (tobacco), 3-10 minutes<br>Smoking (tobacco), 10 minutes and over<br>Smoking (tobacco), group | 99406<br>99407<br>S9453 | O99.330<br>through<br>O99.335 |
| *For More Information: KMAP General Bulletin 19025 Smoking and Tobacco Cessation Counseling and [Billing Guide for Tobacco Screening and Cessation (lung.org)]() for more info.* | | |
| **Other** | | |
| Abnormal Glucose complicating pregnancy | | 099.810 |
| Gestational Diabetes | | 024.419 |
| Gestational Diabetes Mellitus, post-partum | | 024.439 |
| Iron tablets | | 099.019 |

| Paperwork (FMLA) | | Z02.79 |
|---|---|---|
| Prenatal Vitamins | 84591 | Z34.80 |
| Supervision of other high-risk pregnancy | | 009.899 |
| Threatened spontaneous abortion | | 020.0 |

## 7.5 KanCare Specific Kan Be Healthy Components

**KAN Be Healthy (KBH)** is a Title XIX program which provides preventive health care and immediate remedial care for the prevention, correction, or early control of abnormal conditions.

**KBH Participation/Eligibility:** Beneficiaries who are 20 years of age and under are considered KBH-enrolled participants and are eligible for the KBH program until turning 21 years of age. This program is referred to as Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) at the federal level.

**KBH Provider Manuals:** The main source for KBH information is through the state manual. For the current manual, select "KAN Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment" from the dropdown here: ProviderManuals (kmap-state-ks.us)

Additional Manuals and recommendations are available for components including:

- Bright Futures/AAP Periodicity Schedule Bright Futures (KMAP General Bulletin 16058)
- Kansas Guidelines for Hearing Screening HearingScreeningGuidelines.pdf
- Kansas Vision Screening Requirements & Guidelines 1 KDHE KSDE Cover.pdf
- Recommendations for Pediatric Oral Health Assessment, Preventive Services and Anticipatory Guidance/Counseling http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

**KBH Billing Guidance:** KBH screening providers must bill each of the 12 components **separately.** The EP modifier became strictly informational on November 1, 2018. It can be used with any KBH screening code but will no longer result in bundled payment (KMAP General Bulletin 18154).

All KBH screenings must include minimum documentation of the following:

- Medical history
- Physical growth
- Body systems (cardiovascular/pulmonary gastrointestinal, central nervous system, musculoskeletal, genital/urinary, and integumentary systems)
- Developmental/emotional
- Nutrition
- Health education and anticipatory guidance
- Blood lead screening/testing
- Laboratory (CBC w/differential, other as needed)
- Immunizations
- Hearing screen
- Vision screen
- Dental screen

An additional reference guide is available as Appendix 11.10 KBH Specific Billing Reference.

**KBH Required Modifiers:** When doing a Kan-Be-Healthy and immunizations the same visit, you need to add Modifier 25 to the KBH to be paid for both. The billing options include:

- An evaluation and management (E&M) preventative medicine CPT code (99381 through 99385 or 99391 through 99395) with modifier EP.
- An E&M office visit CPT code (99202 through 99205 or 99213 through 99215) with modifier EP and wellness diagnosis code (V20 through V20.2, V20.31, V20.32, V70.0 and/or V70.3 through V70.9), (Z00.00, Z00.01, Z00.121, Z00.129, Z00.110, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8, Z02.89, Z02.0, Z02.1, Z02.2, Z02.3 Z02.4, Z02.5, Z02.6, Z02.82, Z0281, Z02.83, Z02.89)
- An E&M preventative medicine CPT code without modifier EP and 12 components billed separately.
- An E&M office visit CPT code with wellness diagnosis, without modifier EP and 12 components billed separately.

Note: There are additional CPT codes that will update one KBH screen only; additional CPT codes update one medical, dental, vision, or hearing KBH screen.

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| Preventative – Components 1, 2, 3, &6 | | |
| **New Patient** | | |
| 1 day-11 months | 99381 | Z00.121, Z00.129 |
| 1 year-4 years | 99382 | Z00.121, Z00.129 |
| 5 years-11 years | 99383 | Z00.121, Z00.129 |
| 12 years-17 years | 99384 | Z00.121, Z00.129 |
| 18 years-20 years | 99385 | Z00.00, Z00.01 |
| **Established Patient** | | |
| 1 day-11 months | 99391 | Z00.121, Z00.129 |
| 1 year-4 years | 99392 | Z00.121, Z00.129 |
| 5 years-11 years | 99393 | Z00.121, Z00.129 |
| 12 years-17 years | 99394 | Z00.121, Z00.129 |
| 18 years-20 years | 99395 | Z00.00, Z00.01 |
| If an illness or abnormality is encountered, or a preexisting problem is addressed, in the process of performing the preventive medicine service, and if the illness, abnormality, or problem is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management (E/M) service (history, physical examination, medical decision-making, or a combination of those), the appropriate office or other outpatient service code (99202–99215) should be reported in addition to the preventive medicine service code. Modifier 25 should be appended to the office or other outpatient service code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service. | | |
| **Evaluation Management – Component 1, 2, 3, & 6** | | |
| **New Patient** | | |
| Straightforward/minimal (15-29 minutes of total time) | 99202 | |
| Low (30-44 minutes of total time) | 99203 | |
| Moderate (45-59 minutes of total time) | 99204 | |
| High (60-74 minutes of total time) | 99205 | |
| Nurse Visit/Assessment | T1001 | |
| **Established Patient** | | |
| Nurse Visit | 99211 | |
| Straightforward/minimal (10-19 minutes of total time) | 99212 | |
| Low (20-29 minutes of total time) | 99213 | |
| Moderate (30-39 minutes of total time) | 99214 | |
| High (40-54 minutes of total time) | 99215 | |
| **Development and Nutrition – Components 4 & 5** | | |
| Developmental Screening with interpretation and report | 96110 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Brief emotional/behavioral assessment with scoring and documentation per standard instrument | 96127 | Z13.89 |
| Nutrition Assessment; initial assessment, each 15 mins | 97802 | Z71.3 |
| Nutrition Assessment; re-assessment, each 15 mins | 97803 | Z71.3 |
| **Lead – Component 7** | | |
| Lead Screen (in facility) | 83655 | Z13.88 (screen), Z77.011 (exposure) |
| Venipuncture (sent to outside laboratory) | 36415 (Not reimbursable through KanCare) | |

| Laboratory – Component 8 | | |
|---|---|---|
| **Model 1: Blood is drawn in office and specimen is sent to an outside laboratory for analysis** | | |
| Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory | 99000 | |
| Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture | 36406 | |
| Venipuncture, 3 years or older, necessitating physician's skill, not to be used for routine venipuncture | 36410 | |
| **Model 2: Blood is drawn and laboratory tests are performed in the physician's practice** | | |
| Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture | 36406 | |
| Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture) | 36410 | |
| Collection of venous blood by venipuncture | 36415 (Not reimbursable through KanCare) | |
| Collection of capillary blood specimen (e.g., finger, heel, or ear stick) | 36416 | |
| Bilirubin, total | 85018 | |
| Bilirubin, total, transcutaneous | 88720 | |
| Lipid panel (includes total cholesterol, high-density lipoprotein [HDL] cholesterol, and triglycerides) | 80061 | |
| Cholesterol, serum, total | 82465 | |
| Lipoprotein, direct measurement, high-density cholesterol (HDL) | 83718 | |
| Triglycerides | 84478 | |
| Blood count; hemoglobin | 85018 | |
| **Audiology – Component 10** | | |
| Hearing, paper screen | V5008 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Hearing, pure tone, air only | 92551 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Hearing, pure tone audiometry; air only | 92552 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Hearing, pure tone audiometry; air and bone | 92553 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Hearing, speech threshold | 92555 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Hearing, comprehensive evaluation & speech recognition | 92557 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Tympanometry (impedance testing) | 92567 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Acoustic reflex testing, threshold | 92568 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Conditioning play audiometry | 92582 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Evoked response (EEG) audiometry | 92585 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Automated Auditory Brainstem Response | 92586 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Evoked Otoacoustic Emissions; limited | 92587 | Z00.121, Z00.129, Z00.00, Z00.01 |
| **Dental and Vision – Components 11 & 12** | | |
| Vision, bilateral | 99173 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Vision, instrument based for ages 0-3 yr, or who are unable to use vision chart | 99177 | Z00.121, Z00.129, Z00.00, Z00.01 |
| Topical Fluoride Varnish (ADA claim form) | D1206 | Z01.20, Z01.21 |
| Topical Fluoride Varnish, limit 3 applications for dental and | D1208 | Z01.20.Z01.21 |

| | | |
|---|---|---|
| 3 applications for medical, per member (ADA claim form) | | |
| Topical Fluoride Varnish, limit 3 applications for dental and 3 applications for medical, per member (CMS 1500 claim form) | 99188 | Z01.20.Z01.21 |

## 7.6 Lactation Counseling

| Medicaid | | |
|---|---|---|
| Service Description | HCPCS Code | POS Code |
| Lactation classes, non-physician provider, per session | S9443 | |
| Lactation classes, non-physician provider, per session (telemedicine) | S9443<br>S9443 | 02 – Telehealth<br>10 – Telehealth in patient home |
| **Private Insurance** | | |
| Service Description | CPT Code | ICD-10 Code |
| Preventive Individual Counseling (approx. 15 minutes) | 99401 | Z39.1 |
| Preventive Individual Counseling (approx. 30 minutes) | 99402 | Z39.1 |
| Preventive Individual Counseling (approx. 45 minutes) | 99403 | Z39.1 |
| Preventive Individual Counseling (approx. 60 minutes) | 99404 | Z39.1 |

Medicaid Billing - The person providing the service must:

- Have one of the following credentials – International Board-Certified Lactation Consultant (IBCLC), Certified Lactation Counselor (CLC), Certified Breastfeeding Specialist (CBS), or Certified Lactation Educator (CLE). Individuals with these credentials "…*have training and experience providing medical lactation services,*" as required in the KMAP bulletin.
- Certification Records should be on file at the health department.
- NOT be paid by WIC funds to a WIC employee when providing lactation support as a part of the WIC visit. If the services are provided during a non-WIC visit, billing for the service is allowed.

Private Insurance Billing – The person providing the service must:

- Have the following credential - International Board-Certified Lactation Consultant (IBCLC).

*For More Information:*18189 - General - UPDATED - Lactation_Counseling.pdf, 23042 - General - Lactation_Counseling_Allowable_Via_Telemedicine.pdf, 23208 - General - Rate_Increase_for_Lactation_Counseling_Code_S9443.pdf

## 7.7 Elevated Blood Lead (EBL) Education

| Medicaid | | |
|---|---|---|
| Service Description | CPT | ICD-10 |
| Nurse Education (approx. 15 minutes) | T1001 U1 | Z77.011 |

Medicaid Billing eligibility:

- Child aged 0-20 years with an EBL level equal to or greater than 5 mcg/dL taken from venus blood sample.
- Limited to four visits per year
- Education visits apply to all children within a family unit. If more than one child has qualifying EBL level, education must encompass all members and billed under one child's Medicaid ID with a unit of 1.0.

A LHD may consider enrolling and rendering lead hazard assessments (direct or contractor) under a new Provider Type/Provider Specialty (PT/PS) for children aged 0-20 years, if they are shown to have an EBL level equal to or greater than 10 mcg/dL.

*For More Information:* 24180 - General - Lead_Hazard_Risk_Assessments.pdf

# Section 8 - Women's Health Services

## 8.1 Methodologies

**Tobacco Cessation Counseling for Pregnant Women:** Policies and Procedures on counseling visits are located in the Physician Services Manual, Section 903.18.

- Pregnant women that apply for Presumptive Eligibility (PE) and are in Medicaid Fee for Service (FFS) status are eligible to receive PCM services and Tobacco Cessation Counseling during the same visit.
- Codes 99406 or 99407 may be billed along with a distinct E&M service if warranted during the same visit.
- Blue Cross Blue Shield of Kansas will cover one E&M service per day.
- Wellcare will not pay the health departments for prenatal services.
- The Cessation counseling must be face-to-face in a clinic setting.
- For "non-funded WIC" nutritionists who are also qualified as DSPS providers, the counseling visits can be billed (if beyond the two mandatory WIC nutrition counseling visits) in addition to the DSPS Nutritional Counseling service codes.

**340B Pharmaceutical Pricing:** When a covered entity (health department) purchases pharmaceutical products at the 340B price and bills Medicaid/CMOs for the product, the amount billed cannot exceed the entity's actual acquisition cost, plus a dispensing or administration fee as established by the State Medicaid Agency. Note that not all payers cover dispensing or administrative fees.

## 8.2 Family Planning

Modifier 25 can be used to report a significant, separately identifiable E/M service by the same physician on the day of a procedure. Check with payer for specifics.

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| **Preventive/Periodic Well Women** | | |
| New Patient: 12 years - 17 years | 99384 | Z00.121, Z00.129 |
| New Patient: 18 years - 39 years | 99385 | Z00.00, Z00.01 |
| New Patient: 40 years - 64 years | 99386 | Z00.00, Z00.01<br>00 |
| Established Patient: 12 years - 17 years | 99394 | Z00.121 |
| Established Patient: 18 years - 39 years | 99395 | Z00.00, Z00.01 |
| Established Patient: 40 years - 64 years | 99396 | Z00.00, Z00.01 |
| **Examinations** | | |
| Annual Gynecological examination; New Patient | S0610 | Z01.411, Z01.419 |
| Annual Gynecological examination; Established Patient | S0612 | Z01.411, Z01.419 |
| Annual Gynecological examination; clinical breast exam without pelvic exam | S0613 | Z01.411, Z01.419 |
| *NOTE: CPT Codes beginning with "S" are for billing Medicaid/KanCare only.* | | |
| **Evaluation & Management (E/M)** | | |
| Nurse Visit | 99211 | |
| Nurse Visit/Assessment – KanCare Only | T1001 | |
| New Patient: Straightforward/minimal (15-29 minutes of total time) | 99202 | |
| New Patient: Low (30-44 minutes of total time) | 99203 | |
| New Patient: Moderate (45-59 minutes of total time) | 99204 | |
| New Patient: High (60-74 minutes of total time) | 99205 | |
| Established Patient: Straightforward/minimal (10-19 minutes of total time) | 99212 | |
| Established Patient: Low (20-29 minutes of total time) | 99213 | |
| Established Patient: Moderate (30-39 minutes of total time) | 99214 | |
| Established Patient: High (40-54 minutes of total time) | 99215 | |
| **Possible ICD-10 Reason for Visit** | | |
| Anemia | | D64.9 |
| Normal Medical/Lab Exam | | Z00.00 |
| Abnormal Medical/Lab Exam | | Z00.01 |
| Anemia due to blood loss | | D50.0 |
| Anemia due to disturbance of hemoglobin synthesis | | D50.9 |
| BCP Script | | Z30.9 |
| Bacterial Vaginosis (BV) | | N76.0 |
| Breast examination screening | | Z12.39 |
| Breast lump or mass | | N63 |
| Cervicitis | | N72 |
| Condyloma-TCA | | A63.0 |
| Counseling | | Z71.9 |
| Currently Pregnant | | Z33.1 |
| Depo-Provera contraceptive surveillance | | Z30.42 |
| Diabetes Mellitus | | E11.9 |
| Employee/school physical | | Z02.89 |
| Foreign body | | T19.2XXA |
| Galactorrhea in female | | N64.3 |

| | | |
|---|---|---|
| Health Maintenance | | Z00.8 |
| HPV screening/Pap | | Z11.51 |
| IUD surveillance | | Z30.431 |
| Lipid screening | | Z13.220 |
| Mastitis | | N61 |
| Mastodynia | | N64.4 |
| Molluscum Contagiosum | | B08.1 |
| Nexplanon insertion and/or removal | | Z30.8 |
| Oral contraceptive surveillance | | Z30.41 |
| Pap abnormal | | R87.89 |
| Pap screening | | Z12.4 |
| Pap screening repeat | | Z01.42 |
| Post-operative wound infection | | T81.4XXA |
| Preconception counseling | | Z31.69 |
| Screening | | Z13.9 |
| Sickle cell anemia | | D57.1 |
| STD counseling | | Z70.8 |
| STD screening | | Z11.3 |
| Symptom related to IUD | | T83.9XXA |
| Thyroid screening | | Z13.29 |
| Urinary tract infection | | N39.0 |
| Yeast Vaginitis | | B37.3 |
| **Tobacco Screening and Cessation** | | |
| For proper coding, each provider should research the appropriate codes for the services they provide. Please visit [Billing Guide for Tobacco Screening and Cessation (lung.org)] | | |
| Smoking and tobacco counseling; 3 minutes – 10 minutes | 99406 | |
| Smoking and tobacco counseling; 10 minutes or more | 99407 | |
| Smoking cessation classes, non-physician provider, per session | S9453 | |
| Problems Related to Lifestyle and tobacco use not otherwise specified | | Z720 |
| Nicotine dependence. Use the appropriate code for services provided per AAFP link above | | F17200-F17299 |
| **Procedures** | | |
| Insertion, non-biodegradable drug delivery implant | 11981 | |
| Removal, non-biodegradable drug delivery implant | 11982 | |
| Removal *with* reinsertion, non-biodegradable drug delivery implant | 11983 | Z30.433 |
| Insertion of intrauterine device (IUD) | 58300 | Z30.430 |
| Removal of intrauterine device (IUD) | 58301 | Z30.432 |
| Colposcopy of cervix; without biopsy | 57452 | |
| Colposcopy of cervix; with biopsy(s) *and* endocervical curettage | 57454 | |
| Colposcopy of cervix; with biopsy(s) | 57455 | |
| Colposcopy of cervix; with endocervical curettage | 57456 | |
| Colposcopy of cervix; with loop electrode biopsy(s) (LEEP) | 57460 | |
| Colposcopy of cervix; with loop electrode conization of cervix (LEEP) | 57461 | |
| Conization of cervix; loop electrode excision (LEEP) | 57522 | |
| Endometrial sampling (biopsy) | 58100 | |

| Possible Diagnosis Codes (ICD-10) | | |
|---|---|---|
| AGUS | | R87.619 |
| ASCUS | | R87.610 |
| CIN I | | N87.0 |
| CIN II | | N87.1 |
| CIN III | | D06.9 |
| HGSIL | | R87.613 |
| HPV Positive | | R87.810 |
| LGSIL | | R87.612 |
| **Supplies/Pharmacy** | | |
| Contraceptive, condom, female | A4268 | Z30.49 |
| Contraceptive, condom, male | A4267 | Z30.49 |
| Contraceptive, diaphragm | A4266 | Z30.8 |
| Contraceptive, oral | S4993 | Z30.41 |
| Contraceptive, etonogestrel implant (Implanon/Nexplanon) | J7307 | Z30.49 |
| Contraceptive, levonorgestrel releasing intrauterine, 52 mg (Mirena) | J7302 | Z30.430 |
| Contraceptive, intrauterine copper (Paragard) | J7300 | Z30.430 |
| Contraceptive, medroxyprogesterone acetate injection, 1 mg (Depo) | J1050 | Z30.40 |
| Therapeutic, prophylactic or diagnostic injection | 96372 | |

# Section 9 - Adult Health / Miscellaneous Services

## 9.1 Methodologies

**Diagnostic, Screening & Preventive Services (DSPS**): Is a Medicaid category of services solely for public health providers. County Boards of Health are enrolled as qualified Medicaid provider.

Health departments agree to provide diagnostic, screening and treatment services in an office, clinic, school-based clinic, home, or other similar physical facility within the boundaries of the State of Kansas.

**Nutritional Counseling (Individual & Group)**: Dietitians licensed by the Kansas Board of Examiners may bill for Nutritional Counseling. Medicaid reimburses for new patient nutritional assessment, established patient nutritional, counseling, and nutritional group counseling visits.

**Community Health Workers (CHW):** Certified Community Health Workers are billable Medicaid Providers. Billing information is as follows:

| Medicaid | | |
|---|---|---|
| Service Description | CPT Code | Modifier |
| Individual education and training – 30 minutes | 98960 | U7 |
| Small group training involving 2-4 patients | 98961 | U7 |
| Larger group education settings with 5-8 patients | 98962 | U7 |

- Must be provided by a certified CHW.
- Face-to-face with the Medicaid member, individually or in a group.
- Medicaid member's home, the local health department, or other community settings.
- Maximum Time Allowed:
  - Limited to 4 units (or 2 hours) per day, per member.
  - Limited to 24 units (or 12 hours) per month, per member.
- If CHW is not covered by a patient's insurance or the patient is uninsured, each LHD can establish a policy for sliding scale, collection, write-off, etc.
- For additional information: *Part IV Appendices 11.12 Community Health Workers section of this guide.*

**Additional information:**

- MediKan/KanCare will pay for one office visit per client, per date of service. If a client receives a clinical service (nurse) and a nutritional counseling (dietician) service on the same day, billing should reflect the appropriate level of services provided; higher "enhanced" office visit.
- To bill MediKan/KanCare for dispensing TB medicine; providers must perform face-to face, system review services warranting a minimal level office visit.
- Self-Pay Services: Most of our public health departments provide Immunization, Child Health, Women's Health, and Adult Health Services that are covered by our contracted payers. These same services along with other services that are not covered at all may also be provided to patients who have other insurance or are uninsured or underinsured at a set fee. Each County Board of Health sets their own fees for these services and payment may be required at time of service. Listed are a few of the additional services that may be provided at some health departments.
- Health departments can bill for any lab that is processed/analyzed in their lab. Health departments can bill for the collection of lab specimens. Some insurance companies will reimburse for lab collection.
- Attaching modifier 90 (reference laboratory) to venipuncture (36415 – not reimbursable through KanCare) may aid in reimbursement if the outside laboratory that is actually performing the test bills insurance directly for the lab tests. Some insurance companies will deny lab collection as "content of service" to the E/M procedure code.

- For situations where clients bring in medication/injectables (B12, hormone, allergy, etc.), many departments provide this service for a fee and utilize CPT code 96372, "Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular."

## 9.2 Adult Health – Preventative/STD/TB/Nutritional Counseling/MISC

| Service Description | CPT Code | Notes |
|---|---|---|
| **Preventative** | | |
| New Patient: 18 years - 39 years | 99385 | |
| New Patient: 40 years - 64 years | 99386 | |
| Established Patient: 18 years - 39 years | 99395 | |
| Established Patient: 40 years - 64 years | 99396 | |
| **Evaluation & Management** | | |
| Nurse Visit | 99211 | |
| Nurse Visit/Assessment – KanCare Only | T1001 | |
| New Patient: Straight forward/minimal (15-29 minutes of total time) | 99202 | |
| New Patient: Low (30-44 minutes of total time) | 99203 | |
| New Patient: Moderate (45-59 minutes of total time) | 99204 | |
| New Patient: High (60-74 minutes of total time) | 99205 | |
| Established Patient: Straight forward/minimal (10-19 minutes of total time) | 99212 | |
| Established Patient: Low (20-29 minutes of total time) | 99213 | |
| Established Patient: Moderate (30-39 minutes of total time) | 99214 | |
| Established Patient: High (40-54 minutes of total time) | 99215 | |
| **Treatment** | | |
| TCA treatment | E946.4 | A63.0 |
| Azithromycin (chlamydia) | J0456 | A74.9 |
| Bicillin (syphilis) | E930.32 | A53.9 |
| Cefrtiaxone (gonorrhea) | J0696 | A54.9 |
| Doxycycline (syphilis) | E930.4 | A53.9 |
| Metronidazole (trich) | S0030 | A59.9 |
| Allergy Injections | | |
| Allergy injection; single injection | 95115 | |
| Allergy injection; 2 or more injections | 95117 | |
| Nutritional Counseling | | |
| Nutrition Assessment individual; Initial assessment, each 15 mins | 97802 | |
| Nutrition Assessment individual; re-assessment, each 15 mins | 97803 | |
| Nutrition Assessment group; Initial assessment, each 15 mins | 97804 | |
| Special Evaluations & Management Services | | |
| Basic life/Disability evaluation | 99450 | |
| Work related/Medical Disability | 99456 | |

## 9.3 Miscellaneous Services

Fees for these services are set by the local County Boards of Health.

- Prepare Immunization & Hearing, Vision, Dental Certificates w/o service
- Blood Pressure, Height, and Weight Checks
- Copy of Medical Records
- Fax Medical Records
- General Lab Services
- Health Check Services
- International Travel Services
- Lice and Scabies Checks
- Refugee Screening Services
- Childcare Provider Physicals
- Sports Physicals w/ Certificate
- SSI Service

# Section 10 - Laboratory Services

## 10.1 Laboratory

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| **Services** | | |
| 2 Hour Glucose | 82950 | Z86.32 |
| Blood, occult | 82270* | |
| Blood lead | 83655 | Z13.88 (screen), Z77.011 (exposure) |
| Blood sugar | 82948 | |
| Chlamydia trachomatis; amplified probe technique | 87491 | |
| Cholesterol, serum or whole blood | 82465 | |
| Complete blood count (CBC) | 85025 | |
| Finger/Heal stick | 36416 | |
| Gastrin | 82941 | |
| Glucagon tolerance test | 82946 | |
| Glucose | 82947 | |
| Glucose, blood by glucose monitoring device | 82962 | |
| Gonadotropin, chorionic (HCG); quantitative | 84702 | |
| Gonadotropin, chorionic (HCG); qualitative | 84703 | |
| Gonorrhea; amplified probe technique | 87591 | |
| Handling, conveyance of specimen to lab | 99000 | |
| Hematocrit | 85013* | |
| Hemoglobin | 85018 | Z13.0 |
| Hemoglobin; glycosylated (A1C) | 83036 | Z13.1 |
| HEP C | 86803 | Z04.9 |
| HIV-1; antibody | 86701 | |
| HIV-2; antibody | 86702 | |
| HIV-1 and HIV-2; antibody; | 86703 | Z11.59, Z04.9 |
| HIV-1; infectious agent | 87390 | |
| HPV | 87624 | Z01.419 |
| Pap Smear | 88142 | |
| Rubella; antibody | 86762 | |
| Smear; wet mount (e.g., KOH prep, Fern Test) | 87210 | N76.0, N72, B37.3 |
| Smear; Gram or Giemsa stain | 87205 | |
| Surgical pathology (biopsy) | 88305 | |
| Syphilis test (e.g., RPR, VDRL, ART) | 86592 | Z20.2 |
| TB cell mediated immunity response measurement; gamma interferon | 86480 | |
| TB skin Test | 86580 | Z11.1 |
| Tissue exam by KOH, skin, hair, nails | 87220 | |
| Urinalysis; with microscopy | 81000 | R39.9, Z78.9, R82.90 |
| Urinalysis; automated, with microscopy | 81001 | |
| Urinalysis; non-automated, without microscopy | 81002* | |
| Urinalysis; automated, without microscopy | 81003 | |
| Urine pregnancy test, by visual method | 81025 | Z32.00, Z32.01(+), Z32.02 (-) |

| Venipuncture | 36415** |
|---|---|
| ** Codes may require adjustments for QW Modifier. See https://www.aapc.com/blog/45474-new-clia-waived-tests-effective-april-2019/* | |
| *** Not reimbursable through KanCare* | |

## 10.2 CLIA Certification

CMS regulates all laboratory testing performed in the United States through the Clinical Laboratory Improvement Amendments (CLIA). All facilities performing lab services must have an active and valid CLIA certificate with the appropriate CLIA type to submit a claim and receive payment for lab services.

Providers billing for lab services that require the CLIA certification and approved type must ensure current CLIA information is on file with KMAP. The CLIA certificate presented during KMAP provider enrollment or revalidation must match the associated service location of the laboratory.

KMAP will only consider claims for payment when the CLIA certification and type support the procedure and date of service being billed.

Please send **certificates and any questions** to kdhe.clia2@ks.gov

*Note for Blue Cross Blue Shield of Kansas Lab Claims – It is required to submit claims for all covered services. If a member has a lab draw at the Health Department, the claim will need to be submitted to BCBSKS for that service and not billed to the member. If the Health Department wants to be a "draw site only" for labs, the appropriate venipuncture code should be billed to BCBSKS. The lab will need to bill for their services separately. Having BCBSKS members as "Self-Pay" for lab services and instructing them to submit their own claims is not appropriate.*

# PART IV - APPENDICES

## 11.1 Component Requirements for Office/Home Visits

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a recognized health care provider and reported by a specific CPT code(s).

A new patient is one who has not received any professional services from the physician, health care provider or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

Clinicians may use either total practitioner time on the date of service or medical decision making to select a code. There isn't a required level of history or exam for visits 99202—99215.

The level of history and exam is described as “medically appropriate” and is determined by the clinician. History and exam components are required but not used for code selection. Medical decision-making or total time is used for code selection.

If a provider wanted to choose the E/M level based solely on time, documentation within the medical record had to clearly state that counseling and/or coordination of care dominated the service. Total “time” includes both face to face and non-face to face time spent by the clinician.

Basing your E/M level on Medical Decision Making is a bit more involved and requires understanding that the overall complexity of this component is driven by three elements:

- The number and complexity of problems addressed at the encounter
- The amount and/or complexity of data to be reviewed and analyzed
- The risk of complications and/or morbidity or mortality of patient management

Component Requirements for Office Visits

## Elements of Medical Decision Making (MDM)

| Office or Other Outpatient Services | | | | |
|---|---|---|---|---|
| Patient: **New** | | | | |
| **Code** | **99202** | **99203** | **99204** | **99205** |
| Number and Complexity of Problems Addressed | | | | |
| **Minimal** | X | | | |
| **Low** | | X | | |
| **Moderate** | | | X | |
| **High** | | | | X |
| Amount and/or Complexity of Data to be Reviewed and Analyzed | | | | |
| **Minimal or None** | X | | | |
| **Limited** | | X | | |
| **Moderate** | | | X | |
| **Extensive** | | | | X |
| Risk of Complications and/or Morbidity | | | | |
| **Minimal risk** | X | | | |
| **Low risk** | | X | | |
| **Moderate risk** | | | X | |
| **High risk** | | | | X |
| Typical Face-to-Face Time | | | | |
| **Minutes** | 15-29 | 30-44 | 45-59 | 60-74 |

## Elements of Medical Decision Making (MDM)

| Office or Other Outpatient Services | | | | |
|---|---|---|---|---|
| Patient: **Established** | | | | |
| **Code** | **99212** | **99213** | **99214** | **99215** |
| Number and Complexity of Problems Addressed | | | | |
| **Minimal** | X | | | |
| **Low** | | X | | |
| **Moderate** | | | X | |
| **High** | | | | X |
| Amount and/or Complexity of Data to be Reviewed and Analyzed | | | | |
| **Minimal or None** | X | | | |
| **Limited** | | X | | |
| **Moderate** | | | X | |
| **Extensive** | | | | X |
| Risk of Complications and/or Morbidity | | | | |
| **Minimal risk** | X | | | |
| **Low risk** | | X | | |
| **Moderate risk** | | | X | |
| **High risk** | | | | X |
| Typical Face-to-Face Time | | | | |
| **Minutes** | 10-19 | 20-29 | 30-39 | 40-54 |

CPT coding for Evaluation and Management Office visits were revised in 2021 by the American Medical Association (AMA). Details of the changes are reflected on the next page (CPT E/M Office Revisions | AMA). More information can be found here CPT® Evaluation and Management | American Medical Association (ama-assn.org) .

## Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)

**Revisions effective January 1, 2021:**

*Note: this content will not be included in the CPT 2020 code set release*

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| | | Number and Complexity of Problems Addressed | Amount and/or Complexity of Data to be Reviewed and Analyzed<br>**Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.* | Risk of Complications and/or Morbidity or Mortality of Patient Management |
| 99211 | N/A | N/A | N/A | N/A |
| 99202<br>99212 | Straightforward | Minimal<br>• 1 self-limited or minor problem | Minimal or none | Minimal risk of morbidity from additional diagnostic testing or treatment |
| 99203<br>99213 | Low | Low<br>• 2 or more self-limited or minor problems;<br>or<br>• 1 stable chronic illness;<br>or<br>• 1 acute, uncomplicated illness or injury | Limited<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>Category 1: Tests and documents<br>• Any combination of 2 from the following:<br>• Review of prior external note(s) from each unique source*;<br>• review of the result(s) of each unique test*;<br>• ordering of each unique test*<br>or<br>Category 2: Assessment requiring an independent historian(s)<br>*(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* | Low risk of morbidity from additional diagnostic testing or treatment |
| 99204<br>99214 | Moderate | Moderate<br>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>or<br>• 2 or more stable chronic illnesses;<br>or<br>• 1 undiagnosed new problem with uncertain prognosis;<br>or<br>• 1 acute illness with systemic symptoms;<br>or<br>• 1 acute complicated injury | Moderate<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>Category 1: Tests, documents, or independent historian(s)<br>• Any combination of 3 from the following:<br>• Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*;<br>• Assessment requiring an independent historian(s)<br>or<br>Category 2: Independent interpretation of tests<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>or<br>Category 3: Discussion of management or test interpretation<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) | Moderate risk of morbidity from additional diagnostic testing or treatment<br><br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| 99205<br>99215 | High | High<br>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>or<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function | Extensive<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br><br>Category 1: Tests, documents, or independent historian(s)<br>• Any combination of 3 from the following:<br>• Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*;<br>• Assessment requiring an independent historian(s)<br>or<br>Category 2: Independent interpretation of tests<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>or<br>Category 3: Discussion of management or test interpretation<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | High risk of morbidity from additional diagnostic testing or treatment<br><br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

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**Component Requirements for Home Visits**

**Home Services**

**Patient:** New
**Required Components:** 3/3

| Section | Code | 99341 | 99342 | 99343 | 99344 | 99345 |
|---|---|---|---|---|---|---|
| Required Key Components | **History and Exam (#1 and #2)** | | | | | |
| | Problem Focused | x | | | | |
| | Expanded Problem Focused | | x | | | |
| | Detailed | | | x | | |
| | Comprehensive | | | | x | x |
| | **Medical Decision Making (#3)** | | | | | |
| | Straightforward | x | | | | |
| | Low | | x | | | |
| | Moderate | | | x | x | |
| | High | | | | | x |
| Contributory Factors | **Presenting Problem (Severity) (#1)** | | | | | |
| | Low | x | | | | |
| | Moderate | | x | | | |
| | Moderate to High | | | x | | |
| | High | | | | x | |
| | Unstable/Significant New Problem | | | | | x |
| | **Counseling and Coordination of Care (#2 and #3)** See E/M Guidelines | | | | | |
| | **Typical Face-to-Face Time (#4)** | | | | | |
| | Minutes | 20 | 30 | 45 | 60 | 75 |

**Home Services**

**Patient:** Established
**Required Components:** 2/3

| Section | Code | 99347 | 99348 | 99349 | 99350 |
|---|---|---|---|---|---|
| Required Key Components | **Interval History and Exam (#1 and #2)** | | | | |
| | Problem Focused | x | | | |
| | Expanded Problem Focused | | x | | |
| | Detailed | | | x | |
| | Comprehensive | | | | x |
| | **Medical Decision Making (#3)** | | | | |
| | Straightforward | x | | | |
| | Low | | x | | |
| | Moderate | | | x | |
| | Moderate to High | | | | x |
| Contributory Factors | **Presenting Problem (Severity) (#1)** | | | | |
| | Self-Limited or Minor | x | | | |
| | Low to Moderate | | x | | |
| | Moderate to High | | | x | |
| | Moderate to High/Unstable/ Significant New Problem | | | | x |
| | **Counseling and Coordination of Care (#2 and #3)** See E/M Guidelines | | | | |
| | **Typical Face-to-Face Time (#4)** | | | | |
| | Minutes | 15 | 25 | 40 | 60 |

## 11.2 Exclusions

Administration of Vaccines for Children (VFC) vaccines are exempt from third-party liability (TPL). When vaccines are billed with an appropriate administrative code, providers do not have to bill the claim to the TPL carrier before Medicaid will process the claim for payment.

Vaccine codes recognized as VFC covered are below.

| CPT CODE | CVX CODE | Vaccine Name | Coverage |
|---|---|---|---|
| 90380 | 306 | RSV, mAb, nirsevimab-alip, 0.5 mL, neonate to 24 mo. | VFC |
| 90381 | 307 | RSV, mAb, nirsevimab-alip, 1 mL, neonate to 24 mo. | VFC |
| 90622 | 75 | Smallpox (Monkeypox) | |
| 90632 | 52 | Hep A, adult | ADLT |
| 90633 | 83 | Hep A, ped/adol, 2 dose | VFC |
| 90634 | 84 | Hep A, ped/adol, 3 dose | VFC |
| 90636 | 104 | Hep A-Hep B | ADLT |
| 90644 | 148 | Meningococcal C/Y-HIB PRP | VFC |
| 90645 | 47 | Hib (HbOC) | VFC |
| 90646 | 46 | Hib (PRP-D) | VFC |
| 90647 | 49 | Hib (PRP-OMP) | VFC |
| 90648 | 48 | Hib (PRP-T) | VFC |
| 90649 | 62 | HPV, quadrivalent | VFC, ADLT |
| 90650 | 118 | HPV, bivalent | VFC, ADLT |
| 90651 | 165 | HPV9 | VFC |
| 90653 | 168 | influenza, trivalent, adjuvanted | VFC, ADLT |
| 90654 | 144 | influenza, seasonal, intradermal, preservative free | VFC |
| 90655 | 140 | Influenza, seasonal, injectable, preservative free | VFC |
| 90656 | 140 | Influenza, seasonal, injectable, preservative free | VFC, ADLT |
| 90657 | 141 | Influenza, seasonal, injectable | VFC |
| 90658 | 141 | Influenza, seasonal, injectable | VFC, ADLT |
| 90660 | 111 | Influenza, live, intranasal | VFC, ADLT |
| 90669 | 100 | Pneumococcal conjugate PCV 7 | VFC |
| 90670 | 133 | Pneumococcal conjugate PCV 13 | VFC, ADLT |
| 90671 | 215 | Pneumococcal conjugate PCV 15 | VFC, ADLT |
| 90672 | 149 | Influenza, live, intranasal, quadrivalent | VFC, ADLT |
| 90677 | 216 | Pneumococcal conjugate PCV 20 | VFC, ADLT |
| 90678 | 305 | RSV, bivalent | VFC, ADLT |
| 90679 | 303 | RSV, recombinant | ADLT |
| 90680 | 116 | Rotavirus, pentavalent | VFC |
| 90681 | 119 | Rotavirus, monovalent | VFC |
| 90685 | 161 | Influenza, injectable, quadrivalent, preservative free, pediatric | VFC |
| 90686 | 150 | influenza, injectable, quadrivalent, preservative free | VFC, ADLT |
| 90687 | 158 | influenza, injectable, quadrivalent | VFC |
| 90688 | 158 | influenza, injectable, quadrivalent | VFC, ADLT |

| | | | |
|---|---|---|---|
| 90696 | 130 | DTaP-IPV | VFC |
| 90697 | 146 | DTaP-IPV-Hep B-Hib | VFC |
| 90698 | 120 | DTaP-Hib-IPV | VFC |
| 90700 | 20 | DTaP | VFC |
| 90702 | 28 | DT (pediatric) | VFC |
| 90703 | 35 | Tetanus toxoid, adsorbed | VFC |
| 90707 | 03 | MMR (Measles, Mumps, Rubella) | VFC, ADLT |
| 90716 | 21 | Varicella | VFC, ADLT |
| 90720 | 22 | DTP-Hib | VFC |
| 90723 | 110 | DTaP-Hep B-IPV | VFC |
| 90732 | 33 | pneumococcal polysaccharide PPV23 | VFC, ADLT |
| 90733 | 32 | Meningococcal MPSV4 | VFC |
| 90734 | 136 | Meningococcal MCV4O | VFC, ADLT |
| 90734 | 114 | Meningococcal MCV4P, unspecified formulation | VFC, ADLT |
| 90736 | 121 | Zoster, live | ADLT |
| 90739 | 189 | Hep B-CpG | ADLT |
| 90740 | 44 | Hep B, dialysis | ADLT |
| 90743 | 43 | Hep B, adult | VFC |
| 90744 | 08 | Hep B, adolescent or pediatric | VFC |
| 90746 | 43 | Hep B, adult | ADLT |
| 90747 | 43 | Hep B, dialysis | ADLT |
| 90748 | 51 | Hib-Hep B | VFC |
| 90759 | 220 | Hep B (Recombinant) | ADLT |
| 91304 | 313 | COVID-19, subunit | VFC, ADLT |
| 91304 | 211 | COVID-19, subunit | VFC, ADLT |
| 91318 | 308 | COVID-19, mRNA, LNP-S, PF, tris-sucrose, 3 mcg/0.3 mL | VFC |
| 91319 | 310 | COVID-19, mRNA, LNP-S, PF, tris-sucrose, 10 mcg/0.3 mL | VFC |
| 91320 | 309 | COVID-19, mRNA, LNP-S, PF, tris-sucrose, 30 mcg/0.3 mL | VFC, ADLT |
| 91321 | 311 | COVID-19, mRNA, LNP-S, PF, 25 mcg/0.25 mL | VFC |
| 91322 | 312 | COVID-19, mRNA, LNP-S, PF, 50 mcg/0.5 mL | VFC, ADLT |
| Q2035 | | Afluria | VFC |
| Q2036 | | Flulaval | VFC |
| Q2037 | | Fluvirin | VFC |
| Q2038 | | Fluzone | VFC |
| Q2039 | | NOS (not otherwise specified) | VFC |

Sources:

- KMAP Fee-for-Service Provider Manual, Updated 12.2023 (Section 2910. Immunization Administration) General_Benefits_23311_23295.pdf (kmap-state-ks.us)
- CDC CPT Codes Mapped to CVX Codes https://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cpt

The only billable J-Code is depo. When billing drug-related HCPHCS (including all J-Codes), please refer to the NDC requirements, which can be found below.

## Drug-Related HCPCS Codes

Please note the following regarding the list below:

- HCPCS codes listed are not an indication of coverage
- Updated versions will be published at regular intervals
- List reflects what was in effect at the time published and is subject to daily changes

| 90283 | 90375 | 90376 | 90378 | 90384 | 90385 | 90386 | 90389 | 90393 | 90396 |
|---|---|---|---|---|---|---|---|---|---|
| 90399 | 90585 | 90740 | A4216 | A4217 | A4218 | A9500 | A9527 | A9535 | A9536 |
| A9537 | A9540 | A9541 | A9542 | A9543 | A9544 | A9545 | A9546 | A9547 | A9548 |
| A9549 | A9550 | A9551 | A9552 | A9553 | A9554 | A9555 | A9556 | A9557 | A9558 |
| A9559 | A9560 | A9561 | A9562 | A9563 | A9564 | A9565 | A9566 | A9567 | A9568 |
| A9698 | B4164 | B4168 | B4172 | B4176 | B4178 | B4180 | B4185 | B4189 | B4193 |
| B4197 | B4199 | B4216 | B5000 | B5100 | B5200 | C2637 | C9012 | C9017 | C9018 |
| C9224 | C9225 | C9229 | C9230 | C9232 | C9233 | C9234 | C9235 | G9033 | J0120 |
| J0128 | J0129 | J0130 | J0132 | J0133 | J0135 | J0150 | J0152 | J0170 | J0180 |
| J0190 | J0200 | J0205 | J0207 | J0210 | J0215 | J0256 | J0278 | J0280 | J0282 |
| J0285 | J0287 | J0289 | J0290 | J0295 | J0300 | J0330 | J0348 | J0350 | J0360 |
| J0364 | J0365 | J0380 | J0390 | J0456 | J0460 | J0470 | J0475 | J0476 | J0500 |
| J0515 | J0520 | J0530 | J0540 | J0550 | J0560 | J0570 | J0580 | J0583 | J0585 |
| J0587 | J0592 | J0594 | J0595 | J0600 | J0610 | J0620 | J0630 | J0636 | J0637 |
| J0640 | J0670 | J0690 | J0692 | J0694 | J0696 | J0697 | J0698 | J0702 | J0704 |
| J0706 | J0710 | J0713 | J0715 | J0720 | J0725 | J0735 | J0743 | J0744 | J0745 |
| J0760 | J0770 | J0780 | J0795 | J0835 | J0850 | J0878 | J0881 | J0885 | J0894 |
| J0895 | J0900 | J0945 | J0970 | J1000 | J1020 | J1030 | J1040 | J1051 | J1055 |
| J1056 | J1060 | J1070 | J1080 | J1094 | J1100 | J1110 | J1120 | J1160 | J1162 |
| J1165 | J1170 | J1180 | J1190 | J1200 | J1205 | J1212 | J1230 | J1240 | J1245 |
| J1250 | J1260 | J1265 | J1270 | J1320 | J1324 | J1325 | J1327 | J1330 | J1335 |
| J1364 | J1380 | J1390 | J1410 | J1435 | J1436 | J1438 | J1440 | J1441 | J1450 |
| J1451 | J1452 | J1455 | J1458 | J1460 | J1470 | J1480 | J1490 | J1500 | J1510 |
| J1520 | J1530 | J1540 | J1550 | J1560 | J1562 | J1565 | J1566 | J1567 | J1570 |
| J1580 | J1590 | J1600 | J1610 | J1620 | J1626 | J1630 | J1631 | J1642 | J1644 |
| J1645 | J1650 | J1652 | J1655 | J1670 | J1675 | J1700 | J1710 | J1720 | J1730 |
| J1740 | J1745 | J1751 | J1752 | J1756 | J1785 | J1790 | J1800 | J1810 | J1815 |
| J1825 | J1830 | J1835 | J1840 | J1850 | J1885 | J1890 | J1931 | J1940 | J1945 |
| J1950 | J1955 | J1956 | J1960 | J1980 | J1990 | J2001 | J2010 | J2020 | J2060 |
| J2150 | J2170 | J2175 | J2180 | J2185 | J2210 | J2248 | J2250 | J2260 | J2270 |
| J2271 | J2275 | J2278 | J2300 | J2310 | J2315 | J2320 | J2321 | J2322 | J2325 |
| J2330 | J2353 | J2354 | J2355 | J2357 | J2360 | J2370 | J2405 | J2410 | J2425 |
| J2430 | J2440 | J2460 | J2469 | J2501 | J2503 | J2504 | J2505 | J2510 | J2513 |
| J2515 | J2540 | J2543 | J2545 | J2550 | J2560 | J2590 | J2597 | J2650 | J2675 |
| J2680 | J2690 | J2700 | J2710 | J2720 | J2725 | J2730 | J2765 | J2780 | J2783 |

| J2788 | J2790 | J2792 | J2794 | J2795 | J2800 | J2820 | J2850 | J2910 | J2912 |
|---|---|---|---|---|---|---|---|---|---|
| J2916 | J2920 | J2930 | J2940 | J2941 | J2950 | J2993 | J2995 | J2997 | J3010 |
| J3030 | J3070 | J3100 | J3105 | J3120 | J3130 | J3140 | J3150 | J3230 | J3240 |
| J3243 | J3246 | J3250 | J3260 | J3265 | J3280 | J3285 | J3301 | J3302 | J3303 |
| J3305 | J3310 | J3315 | J3320 | J3350 | J3355 | J3360 | J3364 | J3365 | J3370 |
| J3396 | J3400 | J3410 | J3415 | J3420 | J3430 | J3470 | J3471 | J3472 | J3473 |
| J3475 | J3480 | J3486 | J3487 | J3490 | J3520 | J3535 | J3590 | J7030 | J7040 |
| J7042 | J7050 | J7060 | J7070 | J7100 | J7110 | J7120 | J7130 | J7187 | J7188 |
| J7189 | J7190 | J7191 | J7192 | J7193 | J7195 | J7197 | J7300 | J7302 | J7303 |
| J7304 | J7306 | J7311 | J7341 | J7500 | J7501 | J7505 | J7506 | J7507 | J7511 |
| J7513 | J7515 | J7516 | J7517 | J7525 | J7599 | J7607 | J7608 | J7609 | J7610 |
| J7611 | J7612 | J7613 | J7614 | J7615 | J7620 | J7622 | J7624 | J7626 | J7627 |
| J7631 | J7633 | J7634 | J7636 | J7637 | J7638 | J7639 | J7641 | J7642 | J7644 |
| J7645 | J7647 | J7648 | J7649 | J7650 | J7657 | J7658 | J7659 | J7660 | J7667 |
| J7668 | J7669 | J7670 | J7674 | J7684 | J7685 | J7699 | J8498 | J8499 | J8540 |
| J8597 | J8650 | J8999 | J9000 | J9001 | J9010 | J9015 | J9020 | J9025 | J9027 |
| J9031 | J9035 | J9040 | J9041 | J9045 | J9050 | J9055 | J9060 | J9062 | J9065 |
| J9070 | J9080 | J9090 | J9091 | J9092 | J9093 | J9094 | J9095 | J9096 | J9097 |
| J9098 | J9100 | J9110 | J9120 | J9130 | J9140 | J9150 | J9151 | J9160 | J9165 |
| J9170 | J9175 | J9178 | J9181 | J9182 | J9185 | J9190 | J9200 | J9201 | J9202 |
| J9206 | J9208 | J9209 | J9211 | J9212 | J9213 | J9214 | J9215 | J9216 | J9217 |
| J9218 | J9219 | J9225 | J9230 | J9245 | J9250 | J9260 | J9261 | J9263 | J9264 |
| J9265 | J9266 | J9268 | J9270 | J9280 | J9290 | J9291 | J9293 | J9300 | J9305 |
| J9310 | J9320 | J9340 | J9350 | J9355 | J9357 | J9360 | J9370 | J9375 | J9380 |
| J9390 | J9395 | J9600 | J9999 | P9013 | P9014 | P9015 | P9024 | P9041 | P9042 |
| P9043 | P9045 | P9046 | P9047 | P9048 | Q0048 | Q0050 | Q0051 | Q0052 | Q0053 |
| Q0054 | Q0055 | Q0056 | Q0057 | Q0093 | Q0094 | Q0105 | Q0106 | Q0107 | Q0112 |
| Q0125 | Q0138 | Q0139 | Q0140 | Q0141 | Q0142 | Q0143 | Q0144 | Q0156 | Q0157 |
| Q0163 | Q0164 | Q0165 | Q0166 | Q0169 | Q0170 | Q0177 | Q0179 | Q0180 | Q0188 |
| Q0515 | Q2009 | Q2017 | Q3013 | Q4079 | Q4080 | Q4081 | Q4082 | Q9945 | Q9946 |
| Q9947 | Q9948 | Q9949 | Q9950 | Q9951 | Q9952 | Q9953 | Q9954 | Q9955 | Q9956 |
| Q9957 | Q9958 | Q9959 | Q9960 | Q9961 | Q9962 | Q9963 | Q9964 | S0010 | S0011 |
| S0012 | S0014 | S0017 | S0020 | S0021 | S0023 | S0024 | S0028 | S0029 | S0030 |
| S0032 | S0034 | S0039 | S0040 | S0073 | S0074 | S0077 | S0078 | S0080 | S0081 |
| S0090 | S0096 | S0097 | S0098 | S0109 | S0145 | S0147 | S0161 | S0162 | S0166 |
| S0180 | S0190 | S0191 | S0197 | S4993 | S8060 | S9055 | | | |

Effective April 1, 2019, there are 13 new CLIA-waived tests. CMS announced that these apply to facilities with a CLIA certificate of waiver. The modifier QW CLIA waived test must be appended to all but a handful of CPT codes to be recognized as a waived test. Codes not requiring the QW are 81002, 82270, 82272, 82962, 83026, 84830, 85013, and 85651. For more information, visit New CLIA-waived Tests Effective April 2019 - AAPC Knowledge Center.

## 11.3 Vaccine Route of Administration Codes

### Administration without counseling – All ages

| Route: | Injection |
|---|---|
| **CPT Code** | **Description** |
| 90471 | Immunization administration by injection;<br>1 vaccine (single or combination vaccine/toxoid) |
| + 90472 | Immunization administration by injection; *each additional* vaccine (single or combination vaccine/toxoid) |

| Route: | Oral / Intranasal |
|---|---|
| **CPT Code** | **Description** |
| 90473 | Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) |
| + 90474 | Immunization administration by intranasal or oral route; *each additional* vaccine (single or combination vaccine/toxoid) |

### Administration with counseling – 0 – 18 years of age

| Any Route | |
|---|---|
| **CPT Code** | **Description** |
| 90460 | Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; 1 or only component or each vaccine or toxoid |
| + 90461 | Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered |

### Medicare Administration Codes

| Route: | Injection |
|---|---|
| **CPT Code** | **Description** |
| 90471 | Immunization administration by injection;<br>1 vaccine (single or combination vaccine/toxoid) |
| + 90472 | Immunization administration by injection; each additional vaccine (single or combination vaccine/toxoid) |
| **Route:** | **Oral / Intranasal** |
| **CPT Code** | **Description** |
| 90473 | Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) |
| + 90474 | Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) |
| G0008 | Influenza vaccine administration |
| G0009 | Pneumococcal vaccine administration |
| G0010 | Hep B vaccine administration |

## 11.4 Related Links

| Description | Hyperlink |
|---|---|
| CDC Immunization Schedules | Vaccines & Immunizations \| Vaccines & Immunizations \| CDC |
| Advance Beneficiary of Notice and Instructions | MLN006266 – Medicare Advance Written Notices of Non-coverage (cms.gov) |
| Aetna Better Health of KS | NOTE: MCO contract ends 12/31/2024.<br>For Providers \| Aetna Better Health of Kansas |
| Aetna Better Health of KS: Grievance, Resubmission-Reconsideration, Appeals timelines and detailed information | NOTE: MCO contract ends 12/31/2024.<br>Grievances & Appeals \| Aetna Better Health of Kansas |
| Aetna Medicare | Resources & Support for Health Care Providers \| Aetna |
| AMA Coding & Billing | CPT® (Current Procedural Terminology) \| AMA (ama-assn.org) |
| Ask-EDI | ASK-EDI |
| Availity Login | Log In to Availity® |
| Blue Cross and Blue Shield of Kansas, Provider Resources | Professional Provider Home \| Blue Cross and Blue Shield of Kansas (bcbsks.com) |
| Blue Cross and Blue Shield of Kansas, Health Department Billing Guidelines | health-department-billing-guidelines-2022-12-01 (bcbsks.com) |
| Blue Cross and Blue Shield of Kansas, HEDIS Coding and Reference Guide | 2023-hedis-coding-and-reference-guide |
| Centers for Medicare & Medicaid Services | Home - Centers for Medicare & Medicaid Services \| CMS |
| Change Health Care (Optum for Business) | Healthcare Technology & Business Solutions Company \| Change Healthcare |
| Change HealthCare Claims & Denials Advisor (Optum for Business) | Change HealthCare Claims & Denials Advisor |
| Cigna | Cigna Healthcare \| Health Insurance, Dental Plans & Medicare |
| Healthy Blue | Medicaid & Medicare in KS \| Healthy Blue Kansas |
| KMAP training for LHD (Professional) billers | KMAP training for LHD (Professional) Billers |
| KMAP Publications | PublicationsHome (kmap-state-ks.us) |
| Medicare Enrollment and Claim Submission Guidelines | 100-04 \| CMS |
| Medicare WPS | WPS Government Health Administrators (GHA) |
| $4$Navinet | NaviNet Sign In |
| Optum Health Payment Services | Login (optumhealthpaymentservices.com) |
| Payspan | Payspan \| Login Page (payspanhealth.com) |
| Palmetto GBA eServices | Welcome to Palmetto GBA eServices (onlineproviderservices.com) |
| Sunflower Health Plan Manuals and Guides | Provider Manuals, Forms and Resources \| Sunflower Health Plan |
| Sunflower Health Plan Provider Representative Contacts and Territory Map | Kansas Provider Resources \| Kansas Medicaid \| Sunflower Health Plan |
| Sunflower Health Provider Resources | Sunflower Health Plan Provider Portal & Resources \| Sunflower Health Plan |
| Sunflower HEDIS Resource Link: | Sunflower HEDIS Quick Reference Guide (sunflowerhealthplan.com) |
| TransactRx | Transctrx (mytransactrx.net) |
| United Healthcare approved Provider Administrative Guide | Care Provider Manual for Kansas - UnitedHealthcare Community Plan of KanCare (uhcprovider.com) |
| United Healthcare Online | UnitedHealthcare Community Plan of Kansas Homepage \| UHCprovider.com |
| Washington Publishing Company (X12) | External Code Lists \| X12 |

## 11.5 Acronyms and Definitions

| Acronym | Term | Definition |
|---|---|---|
| **ACA** | **Affordable Care Act** | Also referred to as "ObamaCare". A federal law enacted in 2010 intended to increase healthcare coverage and make it more affordable. |
| | **Accept Assignment** | When a provider accepts as "full-payment" the amount paid on a claim by the insurance company, excluding the coinsurance, deductible or co-pay due from the patient |
| | **Adjusted Claim** | A claim that has been corrected, due to an error during submission or payment, which results in a credit or payment to the provider |
| | **Allowed Amount** | The reimbursement rate that the insurance company will pay for a procedure. |
| **AMA** | **American Medical Association** | The AMA is the largest association of Doctors in the United States. They publish the Journal of American Medical Association which is one of the most widely circulated medical journals in the world. |
| | **Aging** | One of the medical billing terms referring to the unpaid insurance claims or patient balances that are due past 30 days. Most medical billing software's have the ability to generate a separate report for insurance aging and patient aging. These reports typically list balances by 30, 60, 90, and 120 day increments. |
| | **Appeal** | When an insurance plan does not pay for treatment, an appeal (either by the provider or patient) is the process of objecting this decision. The insurer may require documentation when processing an appeal and typically has a formal policy or process established for submitting an appeal. Many times the process and associated forms can be found on the insurance provider's web site. |
| | **Applied to Deductible** | You typically see these medical billing terms on the patient statement. This is the amount of the charges, determined by the patients insurance plan, the patient owes the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider. |
| | **Assignment of Benefits** | Insurance payments that are paid to the doctor or hospital for a patient's treatment. |
| | **Beneficiary** | Person or persons covered by the health insurance plan. |
| **BCBS** | **Blue Cross Blue Shield** | An organization of affiliated insurance companies (approximately 450), independent of the association (and each other), that offer insurance plans within local regions under one or both of the association's brands (Blue Cross or Blue Shield). Many local BCBS associations are non-profit BCBS sometimes acts as administrators of Medicare in many states or regions. |
| | **Capitation** | A fixed payment paid per patient enrolled over a defined period of time, paid to a health plan or provider. This covers the costs associated with the patients' health care services. This payment is not affected by the type or number of services provided. |

| | | |
|---|---|---|
| | **Carrier** | The insurance company or "carrier" the patient has a contract with to provide health insurance |
| **CHAMPUS** | **Civilian Health and Medical Program of the Uniformed Services** | Recently renamed TRICARE. This is federal health insurance for active-duty military, National Guard and Reserve, retirees, their families, and survivors. |
| | **Charity Care/Sliding Scale** | When medical care is provided at no cost or at reduced cost to a patient that cannot afford to pay. |
| | **Clean Claim** | Medical billing term for a complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly. |
| | **Clearinghouse** | This is a service that transmits claims to insurance carriers. Prior to submitting claims the clearinghouse scrubs claims and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPPA standards (this is one of the medical billing terms we see a lot more of lately). |
| **CMS** | **Centers for Medicare & Medicaid Services** | Federal agency which administers Medicare, Medicaid, HIPPA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration). You'll notice that CMS is the source of a lot of medical billing terms. |
| | **CMS 1500** | Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on a CMS-1500. The form is distinguished by its red ink. |
| **COB** | **Coordination of Benefits** | Coordination of benefits (COB) applies to a person who is covered by more than one health plan. One insurance carrier is designated as the primary carrier and the other as secondary. |
| | **Coding** | Medical Billing Coding involves taking the doctors notes from a patient visit and translating them into the proper ICD-10 code for diagnosis and CPT codes for treatment. |
| **COBRA** | **Consolidated Omnibus Budget Reconciliation Act** | This is health insurance coverage available to an individual and their dependents after becoming unemployed - either voluntary or involuntary termination of employment for reasons other than gross misconduct. Because it does not typically receive company matching, it's typically more expensive than insurance the cost when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to employees dismissed for a. COBRA stands for Consolidated Omnibus Budget Reconciliation Act which was passed by Congress in 1986. COBRA coverage typically lasts up to 18 months after becoming unemployed and under certain conditions extend up to 36 months. |
| | **Co-Insurance** | Percentage or amount defined in the insurance plan for which the patient is responsible. Most plans have a ratio of 90/10 or 80/20, 70/30, etc. For example, the insurance carrier pays 80% and the patient pays 20%. |
| | **Contractual Adjustment** | The amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company. |
| | **Co-Pay** | Amount paid by patient at each visit as defined by the insured plan. |

| | | |
|---|---|---|
| **CPT Code** | **Current Procedural Terminology** | This is a 5-digit code assigned for reporting a procedure performed by the physician. The CPT has a corresponding diagnosis code. Established by the American Medical Association. This is one of the medical billing terms we use a lot. |
| | **Credentialing** | This is an application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through CAQH. CAQH credentialing process is a universal system now accepted by insurance company networks. |
| | **Credit Balance** | The balance that’s shown in the "Balance" or "Amount Due" column of your account statement with a minus sign after the amount (for example $50-). It may also be shown in parenthesis; ($50). The provider may owe the patient a refund. |
| | **Crossover claim** | When claim information is automatically sent from Medicare the secondary insurance such as Medicaid. |
| **DCI** | **Duplicate Coverage Inquiry** | Request by an insurance company or group medical plan by another insurance company or medical plan to determine if other coverage exists. |
| **DME** | **Durable Medical Equipment** | Non-disposable medical equipment that can withstand repeated use, is used for a medical reason, is not usually useful to someone who isn't sick or injured, is used in the home, and generally has an expected lifetime of at least 3 years. |
| **DOB** | **Date of Birth** | The date on which the person was born. |
| **DOS** | **Date of Service** | Date that health care services were provided. |
| **DX** | **Diagnosis, or Diagnosis Code (ICD-10)** | Abbreviation for diagnosis, or diagnosis code (ICD-10 code) |
| | **Electronic Claim** | Claim information is sent electronically from the billing software to the clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver. |
| **EDI** | **Electronic Data Interchange** | Businesses electronically communicating information that was traditionally communicated on paper. |
| **EFT** | **Electronic Funds Transfer** | An electronic paperless means of transferring money. This allows funds to be transferred, credited, or debited to a bank account and eliminates the need for paper checks. |
| **EIN** | **Employer Identification Number** | Also known as Federal Employer Identification Number, a nine-digit number assigned by the Internal Revenue Service to business entities operating in the United States for the purposes of identification. |
| **E/M** | **Evaluation & Management** | Evaluation and Management section of the CPT codes. These are the CPT codes 99202 thru 99499 most used by physicians or other qualified staff to access (or evaluate) patients’ treatment needs. |
| | **Enrollee** | Individual covered by health insurance. |

| | | |
|---|---|---|
| **EMR** | **Electronic Medical Record** | This is a medical record in digital format of a patient's hospital or provider treatment. |
| **EOB** | **Explanation of Benefits** | One of the medical billing terms for the statement that comes with the insurance company payment to the provider explaining payment details, covered charges, write offs, and patient responsibilities and deductibles. |
| **EOP** | **Explanation of Payment** | A notice of reimbursements and/or denials based on claims processed by your plan. |
| **EOMB** | **Explanation of Medicare Benefits** | A notice of your prescription drug claims and costs. |
| **EPSDT** | **Early & Periodic Screening, Diagnostic, & Treatment** | The child health component of Medicaid for children under the age of 21. |
| **ERA** | **Electronic Remittance Advice** | This is an electronic version of an insurance EOB that provides details of insurance claim payments. These are formatted in according to the HIPAA X12N 835 standard. |
| **ERISA** | **Employee Retirement Income Security Act of 1974** | This law established the reporting, disclosure of grievances, and appeals requirements and financial standards for group life and health. Self-insured plans are regulated by this law. |
| **FFS** | **Fee for Service** | Insurance where the provider is paid for each service or procedure provided. Typically allows patient to choose provider and hospital. Some policies require the patient to pay provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays. |
| | **Fee Schedule** | Cost associated with each treatment CPT medical billing codes. |
| | **Financial Responsibility** | The portion of the charges that are the responsibility of the patient or insured. |
| **FI** | **Fiscal Intermediary** | A Medicare representative who processes Medicare claims. |
| | **Formulary** | A list of prescription drug costs which an insurance company will provide reimbursement for. |
| | **Fraud** | When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means. |
| **GHP** | **Group Health Plan** | A means for one or more employer who provide health benefits or medical care for their employees (or former employees). |
| | **Group Name** | Name of the group or insurance plan that insures the patient. |
| | **Group Number** | Number assigned by insurance company to identify the group under which a patient is insured. |

| | | |
|---|---|---|
| | **Guarantor** | A responsible party and/or insured party who is not a patient. |
| **HC** | **Health Check** | A thorough physical examination including a variety of tests depending on the age and sex and health of the person. |
| **HCFA** | **Health Care Financing Administration** | Now known as CMS |
| **HCPCS** | **Healthcare Common Procedure Coding System** | Commonly pronounced "hick-picks". A standardized medical coding system used to describe specific items or services provided when delivering health services. May also be referred to as a “procedure code” in the medical billing glossary. The three HCPCS levels are:<br>• Level I - American Medical Association’s Current Procedural Terminology (CPT) codes.<br>• Level II - The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.<br>• Level III - Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs. |
| | **Healthcare Insurance** | Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. May be an individual policy or family policy which covers the beneficiary's family members. May include coverage for disability or accidental death or dismemberment. |
| | **Healthcare Provider** | Typically a physician, hospital, nursing facility, or laboratory that provides medical care services. Not to be confused with insurance providers or the organization that provides insurance coverage. |
| **HIC** | **Health Insurance Claim** | This is a number assigned by the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims. |
| **HIPAA** | **Health Insurance Portability & Accountability Act** | Several federal regulations intended to improve the efficiency and effectiveness of health care. HIPAA has introduced a lot of new medical billing terms into our vocabulary lately. |
| **HMO** | **Health Maintenance Organization** | A type of health care plan that places restrictions on treatments. |
| **HSA** | **Health Savings Account** | A tax advantaged medical savings account available to employees who are enrolled in a High-Deductible health plan (HDHP). This account is to be used for medical expenses only. |
| **ICD-9** | **International Classification of Diseases, 9th edition** | 9th revision of the International Classification of Diseases, also known as ICD-9-CM, is a system used to assign 3 to 5 digit codes to patient diagnoses. |
| **ICD-10** | **International Classification of Diseases, 10th edition** | 10th revision of the International Classification of Diseases, also known as ICD-10-CM, is a system used to assign 3 to 7 digit codes to patient diagnoses. Includes additional digits to allow more available codes. ICD-10 was implemented in October 2015 |
| | **Indemnity** | Also referred to as fee-for-service. This is a type of commercial insurance were the patient can use any provider or hospital. |

| | | |
|---|---|---|
| | **In-Network (or Participating)** | An insurance plan in which a provider signs a contract to participate in. The provider agrees to accept a discounted rate for procedures. |
| **MAC** | **Medicare Administrative Contractor** | Contractors who process Medicare claims. |
| **MCO** | **Managed Care Organization** | A health plan with a group of doctors and other providers working together to give health services to its members. |
| | **Managed Care Plan** | Insurance plan requiring patient to see doctors and hospitals that are contracted with the managed care insurance company. Medical emergencies or urgent care are exceptions when out of the managed care plan service area. |
| | **Maximum Out of Pocket** | The maximum amount the insured is responsible for paying for eligible health plan expenses. When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses. |
| **MA** | **Medical Assistant** | A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physician's assistant, nurse, nurse practitioner, etc. |
| | **Medical Coder** | Analyzes patient charts and assigns the appropriate CPT and ICD-10 codes, and any related CPT modifiers. |
| | **Medical Billing Specialist** | Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. Performs tasks vital to the financial operation of a practice. Knowledgeable in medical billing terminology. |
| | **Medical Necessity** | Medical service or procedure that is performed on for treatment of an illness or injury that is not considered investigational, cosmetic, or experimental. |
| **MSA** | **Medical Savings Account** | Tax exempt account for paying medical expenses administered by a third party to reimburse a patient for eligible health care expenses. Typically provided by employer where the employee contributes regularly to the account before taxes and submits claims or receipts for reimbursement. Sometimes also referred to in medical billing terminology as a Medical Spending Account. |
| | **Medical Record Number** | A unique number assigned by the provider or health care facility to identify the patient medical record. |
| | **Medicare** | Insurance provided by federal government for people over 65 or people under 65 with certain restrictions. There are 4 parts:<br>• **Medicare Part A** - Hospital coverage<br>• **Medicare Part B** - Physicians visits and outpatient procedures<br>• Medicare Advantage Plans, sometimes called **Medicare Part C** or MA Plans, are offered by private companies approved by Medicare.<br>• **Medicare Part D** - Medicare insurance for prescription drug costs for anyone enrolled in Medicare Part A or B. |

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| **MSP** | **Medicare Secondary Payer** | Term generally used when the Medicare program does not have primary payment responsibility or when another entity has the responsibility for paying before Medicare. |
| | **Medicare Coinsurance Days** | Medical billing terminology for inpatient hospital coverage from day 61 to day 90 of a continuous hospitalization. The patient is responsible for paying for part of the costs during those days. After the 90th day, the patient enters "Lifetime Reserve Days." |
| | **Medicare Donut Hole** | The gap or difference between the initial limits of insurance and the catastrophic Medicare Part D coverage limits for prescription drugs. |
| | **Medicaid** | Insurance coverage for low-income patients. Funded by Federal and state government and administered by states. |
| | **Medigap** | Medicare supplemental health insurance for Medicare beneficiaries which may include payment of Medicare deductibles, co-insurance and balance bills, or other services not covered by Medicare. |
| | **Modifier** | Added to a CPT treatment code to provide additional information to insurance payers for procedures or services that have been altered or "modified" in some way. Modifiers are important to explain additional procedures and obtain reimbursement for them. |
| **N/C** | **Non-Covered Charge** | A procedure not covered by the patients' health insurance plan. |
| **NDC** | **Nation Drug Code** | A unique 10-digit or 11-digit, 3-segment number, and a universal product identifier for human drugs in the United States. For billing or other purposes, such as with the Centers for Medicare & Medicaid Services (CMS), an NDC may also be arranged in an 11-digit format with leading zeros, if needed. |
| **Non-Par** | **Non-participation** | When a healthcare provider chooses not to accept Medicare approved payment amounts as payment in full. |
| **NEC** | **Not Elsewhere Classifiable** | Medical billing terminology used in ICD when information needed to code the term in a more specific category is not available. |
| **NOS** | **Not Otherwise Classifiable** | Used in ICD for unspecified diagnosis. |
| **NPI** | **National Provider Identifier** | A unique 10-digit identification number required by HIPAA and assigned through the National Plan and Provider Enumeration System (NPPES). |
| **OIG** | **Office of Inspector General** | Part of United States Department of Health and Human Services (USDHHS). Establish compliance requirements to combat healthcare fraud and abuse. Has guidelines for billing services and individual and small group physician practices. |
| | **Out-of-network (or Non-Participating)** | A provider that does not have a contract with the insurance carrier. Patients usually responsible for a greater portion of the charges or may have to pay all the charges for using an out of network provider. |
| | **Out-Of-Pocket Maximum** | The maximum amount the patient has to pay under their insurance policy. Anything above this limit is the insurers' obligation. These Out-of-pocket maximums can apply to all coverage or to a specific benefit category such as prescriptions. |

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|---|---|---|
| | **Outpatient** | Typically treatment in a physician's office, clinic, or day surgery facility lasting less than one day. |
| | **Patient Responsibility** | The amount a patient is responsible for paying that is not covered by the insurance plan. |
| **PCP** | **Primary Care Provider** | Usually the physician who provides initial care and coordinates additional care if necessary. |
| **POS Plan** | **Point-of-Service (POS) Plan** | Medical billing terminology for a flexible type of HMO (Health Maintenance Organization) plan where patients have the freedom to use (or self-refer to) non-HMO network providers. When a non-HMO specialist is seen without referral from the Primary Care Physician (self-referral), they have to pay a higher deductible and a percentage of the coinsurance. |
| **POS** | **Place of Service** | Medical billing terminology used on medical insurance claims - such as the CMS 1500 block 24B. A two-digit code which defines where the procedure was performed. For example, 71 is for the Health Departments and 12 is for home. |
| **PPO** | **Preferred Provider Organization** | Commercial insurance plan where the patient can use any doctor or hospital within the network. Similar to an HMO. |
| | **Practice Management Software** | Software used for the daily operations of a provider's office. Typically used for appointment scheduling and billing. |
| | **Preauthorization** | Requirement of insurance plan for primary care doctor to notify the patient insurance carrier of certain medical procedures (such as outpatient surgery) for those procedures to be considered a covered expense. |
| | **Pre-Certification** | Sometimes required by the patients insurance company to determine medical necessity for the services proposed or rendered. This doesn't guarantee the benefits will be paid. |
| | **Predetermination** | Maximum payment insurance will pay towards surgery, consultation, or other medical care - determined before treatment. |
| **PEC** | **Pre-existing Condition** | A medical illness or injury a patient had before starting a new health care plan. |
| | **Pre-existing Condition Exclusion** | When insurance coverage is denied for the insured when a pre-existing medical condition existed when the health plan coverage became effective. |
| **PHI** | **Protected Health Information** | A medical condition that has been diagnosed or treated within a certain specified period of time just before the patient's effective date of coverage. A Pre-existing condition may not be covered for a determined amount of time as defined in the insurance terms of coverage (typically 6 to 12 months). |
| | **Premium** | The amount the insured or their employer pays (usually monthly) to the health insurance company for coverage. |
| | **Privacy Rule** | The HIPAA privacy standard establishes requirements for disclosing what the HIPAA privacy law calls Protected Health Information (PHI). PHI is any information on a patient about the status of their health, treatment, or payments. |

| | | |
|---|---|---|
| | **Provider** | Physician or medical care facility (hospital) who provides health care services. |
| **PTAN** | **Provider Transaction Access Number** | Also known as the legacy Medicare number. |
| **QMB** | **Qualified Medicare Beneficiary** | An individual who has been determined eligible for the QMB program, under which Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D). |
| | **Referral** | When one provider (usually a family doctor) refers a patient to another provider (typically a specialist). |
| **RVU** | **Relative Value Unit** | Measure of value used by Medicare to determine how much to reimbursement for a procedure by using a formula |
| **R/A** | **Remittance Advice** | A document supplied by the insurance payer with information on claims submitted for payment. Contains explanations for rejected or denied claims. Also referred to as an EOB (Explanation of Benefits). |
| | **Responsible Party** | The person responsible for paying a patient's medical bill. Also referred to as the guarantor. |
| | **Secondary Insurance Claim** | A claim for insurance coverage paid after the primary insurance makes payment. Secondary insurance is typically used to cover gaps in insurance coverage. |
| | **Secondary Procedure** | When a second CPT procedure is performed during the same physician visit as the primary procedure. |
| | **Security Standard** | Provides guidance for developing and implementing policies and procedures to guard and mitigate compromises to security. The HIPAA security standard is kind of a sub-set or compliment to the HIPAA privacy standard. Where the HIPAA policy privacy requirements apply to all patient Protected Health Information (PHI), HIPAA policy security laws apply more specifically to electronic PHI. |
| | **Self-Referral** | When a patient sees a specialist without a primary physician referral. |
| | **Self-Pay** | Payment made at the time of service by the patient. |
| **SOF** | **Signature on File** | Refers to a written signature that is physically on file. This term is typically used whenever an electronic claim is submitted. |
| | **Specialist** | Physician who specializes in a specific area of medicine, such as urology, cardiology, orthopedics, oncology, etc. Some healthcare plans require beneficiaries to obtain a referral from their primary care doctor before making an appointment to see a Specialist. |
| | **Subscriber** | Medical billing term to describe the employee for group policies. For individual policies the subscriber describes the policyholder. |

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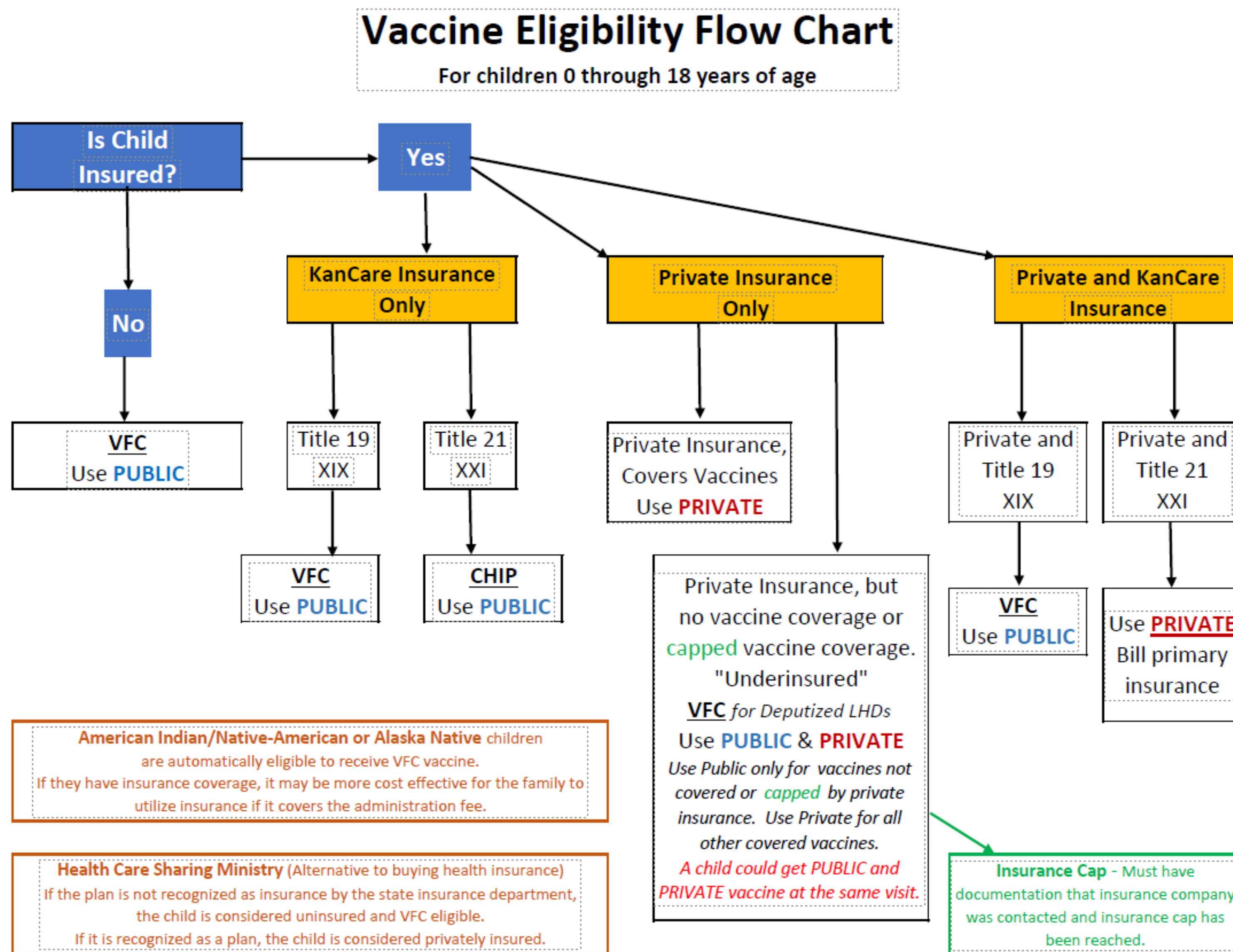
|---|---|---|
| | **Superbill** | One of the medical billing terms for the form the provider uses to document the treatment and diagnosis for a patient visit. Typically includes several commonly used ICD-10 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms. |
| | **Supplemental Insurance** | Additional insurance policy that covers claims for deductibles and coinsurance. Frequently used to cover these expenses not covered by Medicare. |
| **TAR** | **Treatment Authorization Request** | An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered. |
| **TIN** | **Tax Identification Number** | A nine-digit number used as a tracking number by the Internal Revenue Service (IRS), also known as Employer Identification Number (EIN). |
| | **Taxonomy Code** | Specialty standard codes used to indicate a provider's specialty sometimes required to process a claim. |
| | **Term (Termination) Date** | Date the insurance contract expired or the date a subscriber or dependent ceases to be eligible. |
| | **Tertiary Insurance Claim** | Claim for insurance coverage paid in addition to primary and secondary insurance. Tertiary insurance covers gaps in coverage the primary and secondary insurance may not cover. |
| **TOP** | **Triple Option Plan** | An insurance plan which offers the enrolled a choice of a more traditional plan, an HMO, or a PPO. This is also commonly referred to as a cafeteria plan. |
| **TOS** | **Type of Service** | Description of the category of service performed. |
| **TPA** | **Third Party Administrator** | An independent corporate entity or person (third party) who administers group benefits, claims and administration for a self-insured company or group. |
| **TPL** | **Third Party Liability** | Legal obligation of third parties to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. Examples of third parties can include individuals, entities, insurers, and programs. |
| | **Tricare** | This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS. |
| | **Unbundling** | Submitting several CPT treatment codes when only one code is necessary. |
| **UB** | **Uniform Billing** | Uniform electronic billing form pursuant to the Health Insurance Portability and Accountability Act, which is developed as a standard instrument for use by institutions and pyers in the handling of health care claims. |
| **UB04** | **Uniform Institutional Provider Bill** | Claim form for hospitals, clinics, or any provider billing for facility fees similar to CMS 1500. Replaces the UB92 form. |
| **UR** | **Utilization Review** | Review or audit conducted to reduce unnecessary inpatient or outpatient medical services or procedures. |

| | | |
|---|---|---|
| | **Untimely Submission** | Medical claim submitted after the time frame allowed by the insurance payer. Claims submitted after this date are denied. |
| | **Upcoding** | An illegal practice of assigning a diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payer. |
| **UPIN** | **Unique Physician Identification Number** | A 6-digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number. |
| | **Utilization Limit** | The limits that Medicare sets on how many times certain services can be provided within a year. The patients claim can be denied if the services exceed this limit. |
| | **V-Codes** | ICD-9-CM coding classification to identify health care for reasons other than injury or illness. |
| | **Workers Comp** | Insurance claim that results from a work-related injury or illness. |
| | **Write-off** | Typically reference to the difference between what the physician charges and what the insurance plan contractually allows, and the patient is not responsible for. May also be referred to as "not covered" in some glossary of billing terms. |

## 11.6 Vaccine Guidance (Private, VFC and CHIP)



## 11.7 Common EDI Payer ID's

There are multiple options for EDI in Kansas, including ASK, Availity, KMAP, and individual insurance provider websites. A large collection of EDI payer codes is available from ASK at EDI Midwest | ASK-EDI

| Insurance Company Name | ID | ERA | Notes |
|---|---|---|---|
| WPS (Medicare B) | 05202 | Y | |
| Palmetto GBA (Railroad Medicare B) | MR108 | Y | (888) 355-9165. EDI enrollment form listed under Payer Enrollment Forms - All or Multiple States. ERA activation can be found within the EDI enrollment form. |
| Aetna | 60054 | Y | Customer Service: (888) 632-3862.<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Assurant Health | 58730 | N | Customer Service: (888) 632-3862 |
| Benefit Management of Kansas | 48611 | | |
| BlueCross BlueShield of Kansas | 47163 | | Customer Service: (800) 432-3990 |
| BlueCross BlueShield of Nebraska | 00076 | Y | Customer Service: (888) 592-8961<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Champus | 99726 | | Customer Service: (877) 988-9378. Coverage: KS, NE.<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Champva | 99726 | | |
| Cigna | 62308 | Y | Customer Service: (800) 468-3510<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Corporate Benefit Services of America | 41124 | N | Now known as Meritain. Payer ID valid only for claims with a billing submission address of P.O. Box 27267, Minneapolis, MN 55427-0267 |
| Coventry Health Care | 25133 | Y | Coverage: KS, Customer Service: (301) 581-0600<br>Pre-Enrollment is required for Electronic Remittance Advice . |
| Delta Dental of Kansas | CDKS1 | | |
| First Health Network | 73159 | N | |
| Harrington Health | 62061 | | |
| Healthy Blue – KANCARE | 00047 | Y | Availity Customer Service: 800-282-4548 |
| Humana | 61101 | Y | Customer Service: (800) 448-6262<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Medicare of Kansas J5 Part A – UB | 05201 | | |
| Medicaid of Kansas – J5 | 05202 | | |
| Meritain | 41124 | N | SEE Corporate Benefit Services of America. |
| National Telecommunications (NCTA) | 52103 | N | |
| Reserve National | 73066 | N | |
| Sunflower Health Plan - KANCARE | 68069 | Y | Customer Service: (866) 595-8133<br>ERA enrollment forms will be listed under Centene Corporation. |
| The Benefit Group | 88051 | N | |
| Tricare For Life | TDDIR | Y | |
| Tricare West Region | 99726 | Y | Customer Service: (877) 988-9378<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| UMR | 39026 | Y | Customer Service: (877) 233-1800<br>Pre-Enrollment is required for Electronic Remittance Advice |
| United Healthcare Community Plan | 87726 | Y | Customer Service: (866) 633-2446<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| United Healthcare Community Plan of Kansas - KANCARE | 96385 | Y | Pre-Enrollment is required for Electronic Remittance Advice. |

## 11.8 Claim Examples

Medicare, Flu Shot (High Dose)

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA | CARRIER

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JERRY L.

3. PATIENT'S BIRTH DATE (MM DD YY): 03 01 1945 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: TOPEKA STATE: KS

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 08/01/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 321586

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z23 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| Line | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 08 01 16 | 08 01 16 | 60 | | 90662 | | A | 30 00 | 1 | | NPI | 1234567890 |
| 2 | 08 01 16 | 08 01 16 | 60 | | G0008 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 50 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE ON FILE 08/01/2016
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (785) 291-0000
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Medicare, Pneumonia Shot (Prevnar 13)

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

PICA — CARRIER — PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JERRY L.

3. PATIENT'S BIRTH DATE (MM DD YY): 03 01 1945 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: TOPEKA STATE: KS

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 08/01/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 319678

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z23 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| Line | 24A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 08 | 01 | 16 | 08 | 01 | 16 | 60 | | 90670 | | A | 152 00 | 1 | | NPI | 1234567890 |
| 2 | 08 | 01 | 16 | 08 | 01 | 16 | 60 | | G0009 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 3 | | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 172 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNATURE ON FILE 08/01/2016
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (785) 291-0000
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Medicare, Flu Shot (High Dose) and Pneumonia Shot (Prevnar 13)

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

CARRIER

PICA

1. MEDICARE (Medicare#) [X] MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JERRY L.

3. PATIENT'S BIRTH DATE MM DD YY: 03 01 1945 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: TOPEKA STATE: KS

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 08/01/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 319677

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z23 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 08 01 16 | 08 01 16 | 60 | | 90662 | | A | 30 00 | 1 | | NPI | 1234567890 |
| 2 | 08 01 16 | 08 01 16 | 60 | | 90670 | | A | 152 00 | 1 | | NPI | 1234567890 |
| 3 | 08 01 16 | 08 01 16 | 60 | | G0008 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 4 | 08 01 16 | 08 01 16 | 60 | | G0009 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN: 481234567 EIN [X]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 222 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE ON FILE 08/01/2016

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (785) 291-0000
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

VFC, Multiple Vaccines

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA | CARRIER

1. MEDICARE (Medicare#) [X] | MEDICAID (Medicaid#) [ ] | TRICARE (ID#DoD#) [ ] | CHAMPVA (Member ID#) [ ] | GROUP HEALTH PLAN (ID#) [ ] | FECA BLK LUNG (ID#) [ ] | OTHER (ID#) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JERRY C.

3. PATIENT'S BIRTH DATE (MM DD YY): 05 26 2016 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: TOPEKA STATE: KS

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08/01/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 83

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z23 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 08 01 16 | 08 01 16 | 71 | | 90681 | | A | 0 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 2 | 08 01 16 | 08 01 16 | 71 | | 90670 | | A | 0 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 3 | 08 01 16 | 08 01 16 | 71 | | 90744 | | A | 0 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 4 | 08 01 16 | 08 01 16 | 71 | | 90698 | | A | 0 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 5 | 08 01 16 | 08 01 16 | 71 | | 90471 | | A | 20 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 6 | 08 01 16 | 08 01 16 | 71 | | 90472 | | A | 60 00 | 3 | | 1D / NPI | 100000000A / 1234567890 |

25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12890

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 80 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE ON FILE 08/01/2016

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (785) 291-0000
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

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VFC, Flu Mist and HPV

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) [X] MEDICAID (Medicaid#) TRICARE (ID#DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JULIAN R.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 2001 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: TOPEKA STATE: KS

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08/01/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 54

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z23 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 08 01 16 | 08 01 16 | 71 | | 90675 | | A | 0 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 2 | 08 01 16 | 08 01 16 | 71 | | 90651 | | A | 0 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 3 | 08 01 16 | 08 01 16 | 71 | | 90473 | | A | 20 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 4 | 08 01 16 | 08 01 16 | 71 | | 90472 | | A | 20 00 | 1 | | 1D / NPI | 100000000A / 1234567890 |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 481234567 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 12789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 40 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE ON FILE 08/01/2016

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (785) 291-0000
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

STD and Depo

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA | CARRIER

1. MEDICARE [X] (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JILL P.

3. PATIENT'S BIRTH DATE MM DD YY / SEX: 09 23 1978 M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: TOPEKA STATE: KS

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08/01/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 61

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z11.3 B. Z11.59 C. N76.0 D. Z70.8
E. Z30.40 F. Z30.42 G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | 1D | 100000000A |
| | 08 01 16 | 08 01 16 | 71 | | 99213 | | A | 75 00 | 1 | | NPI | 1234567890 |
| 2 | N400009074630 Depo ML150 | | | | | | | | | | 1D | 100000000A |
| | 08 01 16 | 08 01 16 | 71 | | J1050 | | F | 24 00 | 150 | | NPI | 1234567890 |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN: 481234567 EIN [X]

26. PATIENT'S ACCOUNT NO.: 11234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 99 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNATURE ON FILE 08/01/2016
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (785) 291-0000
LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612
a. 1234567890 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Exam and Depo

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE (Medicare#) [X] MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
1a. INSURED'S I.D. NUMBER: 123456789A
2. PATIENT'S NAME: SMITH, JILL P.
3. PATIENT'S BIRTH DATE: 09 23 1978 SEX: F [X]
4. INSURED'S NAME: SAME
5. PATIENT'S ADDRESS: 123 N. MAIN
6. PATIENT RELATIONSHIP TO INSURED: Self [X]
7. INSURED'S ADDRESS:
CITY: TOPEKA STATE: KS
ZIP CODE: 66612 TELEPHONE: (785) 296-0000
8. RESERVED FOR NUCC USE
9. OTHER INSURED'S NAME:
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) NO [X]
b. AUTO ACCIDENT? NO [X]
c. OTHER ACCIDENT? NO [X]
10d. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER:
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO [X]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 08/01/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
15. OTHER DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 73
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: ICD Ind. 0
A. Z01.419 B. Z11.3 C. Z71.9 D. Z11.59
E. Z30.42
22. RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

| Line | 24A. Date(s) of Service From | To | B. Place of Service | D. CPT/HCPCS | E. Diagnosis Pointer | F. $ Charges | G. Days or Units | I. ID Qual. | J. Rendering Provider ID # |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 08 01 16 | 08 01 16 | 71 | S0610 | A | 120 00 | 1 | 1D / NPI | 100000000A / 1234567890 |
| 2 (N400009074630 Depo ML150) | 08 01 16 | 08 01 16 | 71 | J1050 | E | 24 00 | 150 | 1D / NPI | 100000000A / 1234567890 |
| 3 | | | | | | | | NPI | |
| 4 | | | | | | | | NPI | |
| 5 | | | | | | | | NPI | |
| 6 | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 481234567 EIN [X]
26. PATIENT'S ACCOUNT NO.: 11234
27. ACCEPT ASSIGNMENT? YES [X]
28. TOTAL CHARGE: $ 144 00
29. AMOUNT PAID: $ 0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER: SIGNATURE ON FILE DATE: 08/01/2016
32. SERVICE FACILITY LOCATION INFORMATION: LOCAL HEALTH DEPARTMENT, 201 N. CENTRAL, TOPEKA, KS 66612; a. 1234567890
33. BILLING PROVIDER INFO & PH #: (785) 291-0000 LOCAL HEALTH DEPARTMENT, 201 N. CENTRAL, TOPEKA, KS 66612; a. 1234567890

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

## 11.9 National Drug Code Conversion Table

A National Drug Code (NDC) has three segments:

- The first segment is 5 digits long and is assigned by the Food and Drug Administration (FDA) to identify the facility that manufactures, repacks or distributes the drug product.
- The second segment is 4 digits long and identifies a specific strength, dosage form, and formulation for a particular product.
- The third segment is 2 digits long and identifies package forms and sizes,

Proper billing requires an 11-digit number in the 5-4-2 format. The NDC may be displayed on the package in a 10-digit format. Converting the NDC from 10 to 11 digits requires adding a zero to the beginning of the segment that is too short. The following table shows where to add the zero. The example is shown in bold and underlined solely to illustrate the examples.

**Converting NDCs from 10 to 11 digits.**

| 10-Digit Example | 11-Digit Example | Actual NDC Conversion | | Claim NDC |
|---|---|---|---|---|
| 9999 – 9999 – 99<br>4 – 4 – 2 | 09999 – 9999 – 99<br>5 – 4 – 2 | 0002-7597-01 | 00002-7597-01 | 00002759701 |
| 99999 – 999 – 99<br>5 – 3 – 2 | 99999 – 0999 – 99<br>5 – 4 – 2 | 50242-040-62 | 50242-0040-62 | 50242004062 |
| 99999 – 9999 – 9<br>5 – 4 – 1 | 99999 –9999 – 09<br>5 – 4 – 2 | 60575-4112-1 | 60575-4112-01 | 60575411201 |
| Do not use hyphens when entering the actual data in your claim. | | | | |

## 11.10 Local Health Department Kan-Be-Healthy Billing Reference Tool: KanCare Only

| Preventative | | | |
|---|---|---|---|
| **Age (New Pt)** | **CPT Code** | **ICD-10 Code** | **Reimbursement** |
| 1 day-11 months | 99381 | Z00.121, Z00.129 | $70.00 |
| 1 year-4 years | 99382 | Z00.121, Z00.129 | $70.00 |
| 5 years-11 years | 99383 | Z00.121, Z00.129 | $70.00 |
| 12 years-17 years | 99384 | Z00.121, Z00.129 | $70.00 |
| 18 years-20 years | 99385 | Z00.00, Z00.01 | $70.00 |
| **Age (Est. Pt)** | **CPT Code** | **ICD-10 Code** | **Reimbursement** |
| 1 day-11 months | 99391 | Z00.121, Z00.129 | $70.00 |
| 1 year-4 years | 99392 | Z00.121, Z00.129 | $70.00 |
| 5 years-11 years | 99393 | Z00.121, Z00.129 | $70.00 |
| 12 years-17 years | 99394 | Z00.121, Z00.129 | $70.00 |
| 18 years-20 years | 99395 | Z00.00, Z00.01 | $70.00 |

| Evaluation Management | | |
|---|---|---|
| **Service (New Pt)** | **CPT Code** | **Reimbursement** |
| Straightforward/Minimal (15-29 min) | 99202 | $50.66 |
| Low (30-44 min) | 99203 | $75.45 |
| Moderate (45-59 min) | 99204 | $107.12 |
| High (60-74 min) | 99205 | $136.62 |
| Nurse Visit/Assessment (KanCare only) | T1001 | $30.00 |
| **Service (Est. Pt)** | **CPT Code** | **Reimbursement** |
| Nurse Visit | 99211 | $16.36 |
| Straight forward/minimal (10-19 min) | 99212 | $29.76 |
| Low (20-29 min) | 99213 | $40.84 |
| Moderate (30-39 min) | 99214 | $64.22 |
| High (40-54 min) | 99215 | $94.00 |

| Development and Nutrition | | | |
|---|---|---|---|
| **Service** | **CPT Code** | **ICD-10-CM Code** | **Reimbursement** |
| Developmental Screening with interpretation and report | 96110 | Z00.121, Z00.129, Z00.00, Z00.01 | $31.50 |
| Brief emotional/behavioral assessment with scoring and documentation per standard instrument | 96127 | Z13.89 | $3.09 |
| Nutrition Assessment; initial assessment, each 15 mins | 97802 | Z71.3 | $21.20 |
| Nutrition Assessment; re-assessment, each 15 mins | 97803 | Z71.3 | $20.00 |

| Lead | | | |
|---|---|---|---|
| **Service** | **CPT Code** | **ICD-10-CM Code** | **Reimbursement** |
| Lead Screen (in facility) | 83655 | Z13.88 (screen), Z77011 (exposure) | $11.70 |
| Venipuncture (sent to outside laboratory) | 36415 (Not reimbursable through KanCare) | | - |

## Audiology

| Service | CPT Code | ICD-10 Code | Reimbursement |
|---|---|---|---|
| Hearing, pure tone, air only | 92551 | Z00.121, Z00.129, Z00.00, Z00.01 | $13.83 |
| Hearing, pure tone audiometry; air only | 92552 | Z00.121, Z00.129, Z00.00, Z00.01 | $15.28 |
| Hearing, pure tone audiometry; air and bone | 92553 | Z00.121, Z00.129, Z00.00, Z00.01 | $20.97 |
| Hearing, speech threshold | 92555 | Z00.121, Z00.129, Z00.00, Z00.01 | $11.94 |
| Hearing, comprehensive evaluation & speech recognition | 92557 | Z00.121, Z00.129, Z00.00, Z00.01 | $39.77 |
| Tympanometry (impedance testing) | 92567 | Z00.121, Z00.129, Z00.00, Z00.01 | $16.08 |
| Acoustic reflex testing, threshold | 92568 | Z00.121, Z00.129, Z00.00, Z00.01 | - |
| Conditioning play audiometry | 92582 | Z00.121, Z00.129, Z00.00, Z00.01 | - |
| Evoked response (EEG) audiometry | 92585 | Z00.121, Z00.129, Z00.00, Z00.01 | $75.23 |
| Automated Auditory Brainstem Response | 92586 | Z00.121, Z00.129, Z00.00, Z00.01 | - |
| Evoked Otoacoustic Emissions; limited | 92587 | Z00.121, Z00.129, Z00.00, Z00.01 | $44.67 |

## *Laboratory*

| **Model 1: Blood is drawn in office and specimen is sent to an outside laboratory for analysis** | | |
|---|---|---|
| **Service** | **CPT Code** | **Reimbursement** |
| Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory | 99000 | Included in preventative/ E&M |
| Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture | 36406 | $13.63 |
| Venipuncture, 3 years or older, necessitating physician's skill, not to be used for routine venipuncture | 36410 | $13.90 |

| **Model 2: Blood is drawn and laboratory tests are performed in the physician's practice** | | |
|---|---|---|
| **Service** | **CPT Code** | **Reimbursement** |
| Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture | 36406 | $13.63 |
| Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture) | 36410 | $13.90 |
| Collection of venous blood by venipuncture | 36415 (Not reimbursable through KanCare) | - |
| Collection of capillary blood specimen (e.g., finger, heel, or ear stick) | 36416 | - |
| Bilirubin, total | 85018 | $1.31 |
| Bilirubin, total, transcutaneous | 88720 | $6.25 |
| Lipid panel (includes total cholesterol, high-density lipoprotein [HDL] cholesterol, and triglycerides) | 80061 | $15.12 |
| Cholesterol, serum, total | 82465 | $6.01 |
| Lipoprotein, direct measurement, high-density cholesterol (HDL) | 83718 | $11.25 |
| Triglycerides | 84478 | $6.30 |
| Blood count; hemoglobin | 85018 | $1.31 |

## Dental and Vision

| Service | CPT Code | ICD-10 Code | Reimbursement |
|---|---|---|---|
| Vision, bilateral | 99173 | Z00.121, Z00.129, Z00.00, Z00.01 | $5.00 |
| Topical Fluoride Varnish | D1206 | Z01.20, Z01.21 | - |
| Topical Application of Fluoride | D0120 | | - |

## Immunizations

Please see appropriate immunization codes for immunizations.

All information listed here is for reference and suggestion only.

Please review all requirements for service and documentation prior to utilizing any listed CPT or ICD-10 codes.

Information for this reference tool can be found in the KBH Manual (KBH_24242_24196.pdf) as well as the AAP Bright Futures guide (Coding Preventive Care.pdf).

All reimbursement rates listed are accurate as of February 1, 2019. To view current reimbursement rates:

1. Go to https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/HCPCSSearch?searchBy=HCPCS
1. Accept the terms and conditions
2. Enter the code in the HCPCS box
3. Choose “Title XIX” for the benefit plan
4. Chooses provider type 13
5. Choose provider specialty #131.

## 11.11 Social Determinants of Health Z-Codes

Summary of Z-Codes

**What is a Social Determinant of Health (SDoH)?**

Social Determinants of Health are the conditions by which we are, born, live, work, and grow up; and the forces that shape these conditions (WHO, 2018). Examples include societal and environmental conditions such as food, housing, transportation, education, violence, social support, health behaviors and employment. Studies have demonstrated a link between economic status, social factors, and physical environment **as key influences in health outcomes**.

**What is a SDoH Z-Code?**

*Z*-Codes are standardized measures for a circumstance or problem that is present which influences the person's health status but is not in itself a current illness or injury. There is a section of codes for Social Determinants of Health that are introduced in the 10th revision of ICD-10-CM Official Guidelines for Coding and Reporting (categories Z55-Z65). They align with SDoH categories and identify problems/risk factors, diagnosing the patient with potential health hazards related to socioeconomic and psychosocial circumstances.

### Why are SDoH Z-Codes used?

Use of Z-Codes impacts both the patient and the community. In patient care, they improve care coordination, referrals, and follow-up services. They help providers and partners help address the root causes of some health issues. Collective use for a community informs state and local governments about community needs and can support planning and implementation of social needs intervention.

**Why should we use them?**

Local Health Departments have an opportunity to collect and use codes internally for patient care, as well for as for client and population data analysis. Add to this that Managed Care Organizations (MCO) will actively use the codes to follow up with the patients and to address SDoH needs, including referrals to area organizations. Currently, there is no additional reimbursement for reporting Z-Codes.

**Where can we learn more?**

- The Social Determinants of Health Academy is a HRSA funded training and technical assistance provider. They offer a coordinated curriculum of community-based SDOH Interventions. The SDOH Academy
- CMS.gov – Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes (.pdf) USING Z CODES
- CMS.gov – Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes (.pdf) IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

**How are the Z-Codes Organized?**

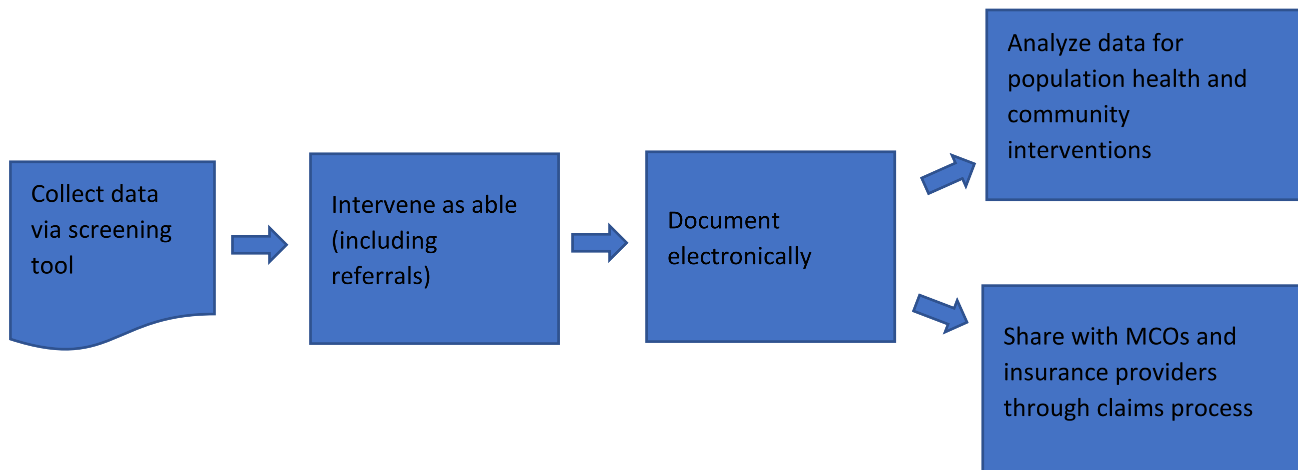
The full list of Z-Codes is numerous. They are organized into categories ranging from Z00 to Z99, with multiple individual codes listed within each category. Z-Codes related to Social Determinants of Health are in categories numbering Z55 to Z91 as listed below.

| List of Popular Z-Code Categories | |
|---|---|
| Z55 | Problems related to education and literacy |
| Z56 | Problems related to employment and unemployment |
| Z57 | Occupational exposure to risk factors |
| Z59 | Problems related to housing and economic circumstances |
| Z60 | Problems related to social environment |
| Z62 | Problems related to upbringing |
| Z63 | Other problems related to primary supports group, including family circumstances |
| Z64 | Problems related to certain psychosocial circumstances |
| Z65 | Problems related to other psychosocial circumstances |
| Z72 | Problems related to lifestyle |
| Z73 | Problems related to life management difficulty |
| Z74 | Problems related to care provider dependency |
| Z75 | Problems related to medical facilities and other health care |
| Z77 | Other contact with and (suspected) exposures hazardous to health |
| Z91 | Personal risk factors, not elsewhere classified |

## Z-Codes Implementation and Use

**What does the process look like to collect and "implement" SDoH Z-codes?**

There are multiple processes and steps to effectively implementing the collection and use of Z-codes. Each local health department will look a little different and their capacity to intervene and make use of the data will vary. Overall the process should resemble the following:



**What are some commonly used screening tools?**

There are multiple screening tools available, with some customized for specific patient populations (e.g. MCH). Federally Qualified Health Centers (FQHC) use the PRAPARE tool from National Association of Community Health Centers. An abbreviated list is here:

- AAFP: Guide to social needs screening (aafp.org)
- AHC CDC: The AHC Health-Related Social Needs Screening Tool (cms.gov)
- CAHMI: Microsoft Word - Appendices to TWG statement design (cahmi.org)
- Johns Hopkins Healthcare: PRUP135_ICD10-km.pdf (hopkinsmedicine.org)
- PRAPARE (NACHC): PRAPARE Toolkit - PRAPARE

**How are interventions determined?**

Each Local Health Department should create a plan of action for any screening question response. Interventions will vary based on the community and its resources. Many interventions might be addressed secondarily through a referral process or program. If your community does not utilize a referral platform, look into championing the use of one or more used across the county. While paper and the telephone can still be used in making referrals, using electronic systems gives the community a documented and measurable intervention, as well and a documented way for follow-up.

There are a number of referral platforms being used in the state. Several popular ones in use by KanCare and other insurance providers include:

- findhelp (formerly known as Aunt Bertha) - findhelp.org by findhelp - Search and Connect to Social Care
- 211 of Kansas - Home (myresourcedirectory.com)
- Healthify – WellSky Solutions (healthify.us)
- DAISEY – DAISEY Solutions

**What codes should be collected and documented by Local Health Departments?**

Below is a list of the codes that Local Health Department should consider collecting, along with sample questions an LHD might utilize to obtain and measure responses to justify if a code is warranted. Much like other ICD-10 codes, the Z-codes should only be recorded in the system if the response notes that this specific condition or event is a possible factor contributing to poor health.

| Code | Description | Source |
|---|---|---|
| Z55.1 | **Schooling unavailable or unattainable** | |
| | What is the highest level of school that you have finished? | PRAPARE Pg. 87 |
| | Do you have a high school diploma? | AAFP |
| Z56.0 | **Unemployment, unspecified** | |
| | What is your current work situation? | PRAPARE Pg. 90 |
| | Do you have a job? | AAFP |
| Z57 | **Occupational exposure to risk factors** | |
| | What is your current work situation? | PRAPARE Pg. 90 |
| | Do you have occupational exposure to noise, dust, tobacco smoke, air contaminants, toxic agents in agriculture, toxic agents in other industries, etc. | Johns Hopkins |
| Z59.0 | **Homelessness** | |
| | What is your housing situation today? | PRAPARE Pg. 95 |
| | Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household? | AAFP |
| Z59.4 | **Lack of adequate food and safe drinking water** | |
| | What address do you live at? | PRAPARE Pg. 108 |
| | Within the past 12 months, you worried that your food would run out before you got money to buy more. | AAFP |
| | Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more. | AAFP |
| Z59.7 | **Insufficient social insurance and welfare support** | |
| | What was the total combined income for you and the family members you live with? | PRAPARE Pg. 97 |
| | How often does this describe you? I don’t have enough money to pay my bills. | AAFP |
| Z60.4 | **Social exclusion and rejection** | |
| | How often do you see or talk to people that you care about and feel close to? | PRAPARE Pg. 113 |
| | I feel valued and accepted and included by my family and my community. | CAHMI |
| Z63 | **Other problems related to primary supports group, including family circumstances** | |
| | Do you feel physically and emotionally safe where you currently live? | PRAPARE Pg. 111 |
| | In the past year, have you been afraid of your partner or ex-partner? | PRAPARE Pg. 111 |
| Z73.3 | **Stress, not elsewhere classified** | |
| | (Stress is when someone feels tense, nervous, anxious, or can’t sleep at night because their mind is troubled.) I am often stressed in my day-to-day life and activities. | CAHMI |
| | I can express my emotions, set limits for myself, and calm myself down. | CAHMI |

**Who can I reach out to about additional questions in this matter?**

The WSU Center for Public Health Initiative is currently working with the Kansas Association of Local health Departments, along with multiple KanCare MCOs to explore and expand the use of social determinant Z-codes. For follow-up questions or support please email cphi@wichita.edu.

## 11.12 Community Health Workers

Medicaid Reimbursement is Available for

Community Health Workers (CHW)

As of July 2023, Medicaid has deemed certified Community Health Workers (CHW) as billable Medicaid Providers. Below is a summary of known information about the certification process and the Medicaid billing process for LHD's providing services by a CHW.

Community Health Worker – General Information:

What role does a Community Health Worker (CHW) play in Kansas public health?

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. For more information, go to www.kschw.org.

How to become a Certified Community Health Worker

Certification is a formal process, but once complete it remains active for two years. There are two options for completing certification recognized by the Kansas Department of Health and Environment (KDHE):

1. **Education Pathway**: Applicant must complete the KDHE approved CHW training program through the Kansas CHW coalition or certified Kansas CHW education provider. The average timeline until certification is 20 weeks.
2. **Work Experience Pathway**: Applicant must complete 800 hours over three years plus three letters of recommendation to document work and/or volunteer experience. The average timeline for application review is 2-3 weeks following receipt of the application.

- More information on CHW certification can be found here: https://kschw.org/certification/
- Application Form: CHW Certification Application

What services can a certified CHW provide?

- Screening and assessment to identify health-related social needs and barriers to accessing health care.
- Health promotion and coaching to assist members to set goals and action plans to address health-related social needs and barriers to accessing health care; and provide information, coaching, and support to assist members to engage and re-engage in their own health care including adherence to treatment plans, follow up with necessary health care, and self-management of chronic conditions.
- Health system navigation and resource coordination and groups of members, consistent with established or recognized health care standards, on methods and measures to prevent disease, disability, and other health conditions or their progression.
- Care planning with a member's care team to support a person-centered holistic approach to care delivery to promote physical and mental health and efficiency, and to address health-related social needs and barriers to accessing health care.

Who provides supervision for a certified CHW?

Supervision of the certified CHW is included in the scope of practice for each supervising licensed practitioner. Each supervising licensed practitioner shall assume professional responsibility for the services provided by the certified CHW and attest to the CHW's certification.

Billing Information for Local Health Departments:

What services qualify for LHD Billing?

- Must be provided by a certified CHW.
- Face-to-face with the Medicaid member, individually or in a group.
- Medicaid member's home, the local health department, or other community settings.
- Maximum Time Allowed:
  - Limited to 4 units (or 2 hours) per day, per member.
  - Limited to 24 units (or 12 hours) per month, per member.

Are LHD's eligible to bill for CHW services?

Yes. The services must be billed using the individual or individual group member National Provider Identification (NPI). These services are NOT reimbursable to a Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), or Indian Health Center (IHC). If the RHC/FQHC/IHC shares an NPI with the physician group, reimbursement should be to the physician group only.

What are the codes and reimbursement rates?

Rates effective July 1, 2024 are as follows:

| Procedure Code | Code Definition | Rate* |
|---|---|---|
| 98960 U7 | Individual education and training – 30 minutes | $22.20 |
| 98961 U7 | Small group training involving 2-4 patients | $10.78 |
| 98962 U7 | Larger group education settings with 5-8 patients | $7.77 |

* *The rates noted in this bulletin are subject to future changes. Providers should check the Kansas Medical Assistance Program (KMAP) website for the most up-to-date rates*

Do I need a modifier?

Yes. When billing these services, providers must append modifier U7 to codes 98960, 98961, and 98962 to indicate the CHW has met the required training requirements and has received a certificate of completion. The billing provider must maintain documentation of CHW certification and background checks for the individual providing the CHW services.

What about patients not covered by Medicaid?

If CHW services are not covered by a patient's insurance coverage, or the patient is uninsured, each LHD can establish a policy for sliding scale, collection, write-off, etc.

Reference Documents:

- General Bulletin 23175 outlines what codes can be used, coverage limitations, billing instructions, CHW qualifications, and listed services (July 2023): KMAP General Bulletin 23175 UPDATED
- General Bulletin 23343 defines payment through NPI number, and instructions for LHD's associated with RHC/FQHC/IHC organizations (December 2023): KMAP General Bulletin 23343
- General Bulletin 24105 provides rate updates effective SFY25 (June 2024): KMAP General Bulletin 24105
- For more information and updates, go to the KMAP Provider Bulletins webpage: https://portal.kmap-state-ks.us/PublicPage/Public/Bulletins/