Kansas Local Health Department Clinical Services Coding

Resource Guide

UPDATED: DECEMBER 2023

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.

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

Kansas Department of Health and Environment

KALHD Kansas Association of Local Health Departments

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 for Immunization Services:

- Sunflower State Health Plan
- Aetna 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	Updated to reflect new Part I addition.
Part I – Opportunities to Connect	NEW – Created section with information moved from appendices (KALHD Billing Listserv Enrollment, Regional Billing Groups, Kansas Department of Health and Environment and LHD Contacts) and HER Platforms used by LHD map. • KALHD Listserv – Updated options and registration information. • Regional Billing Groups – Updated contacts.
1.2 Medicaid Enrollment Process	New bullet point for contracting as ancillary facility
1.3 Private Insurance Enrollment Process	Updated link for Aetna Better Health of Kansas
2.2 Eligibility & Verification	Updated link for 2024 Member Open Enrollment
4.2 Filing Time Limits	Updated link for BCBS of KS retrospective review requests
4.5 Medicaid Denial Issues	Updated link for KanCare Providers Frequently Asked Questions
6.3 Immunizations 18 yrs. of age and younger	Added Meningococcal Group B (Bexsero) (90620)
6.4 Immunizations 19 yrs. of age and older	Added Meningococcal Group B (Bexsero) (90620)
6.7 Influenza Vaccine Products	Updated for 2023-2024 Season
6.8 Covid-19 Products	NEW – Covid-19 vaccination and administration code table
6.9 RSV Products	NEW – RSV vaccination code table
7.2 Child Health Visits	Deleted Topical App of Fluoride (D1208)
7.5 KanCare Specific KBH Components	Deleted Topical Application of Fluoride (D0120)
7.6 Lactation Counseling	NEW – Lactation Counseling codes and credentialing requirements
11.2 Exclusions	Updated table for VFC vaccines exempt from TPL
11.4 Related Links	• Updated link for Aetna Medicare • Updated link for Change HealthCare Claims & Denials Advisor

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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 Department of Health and Environment and Local Health Department Contacts

Kansas Regional Public Health Map

Updated December 5, 2023

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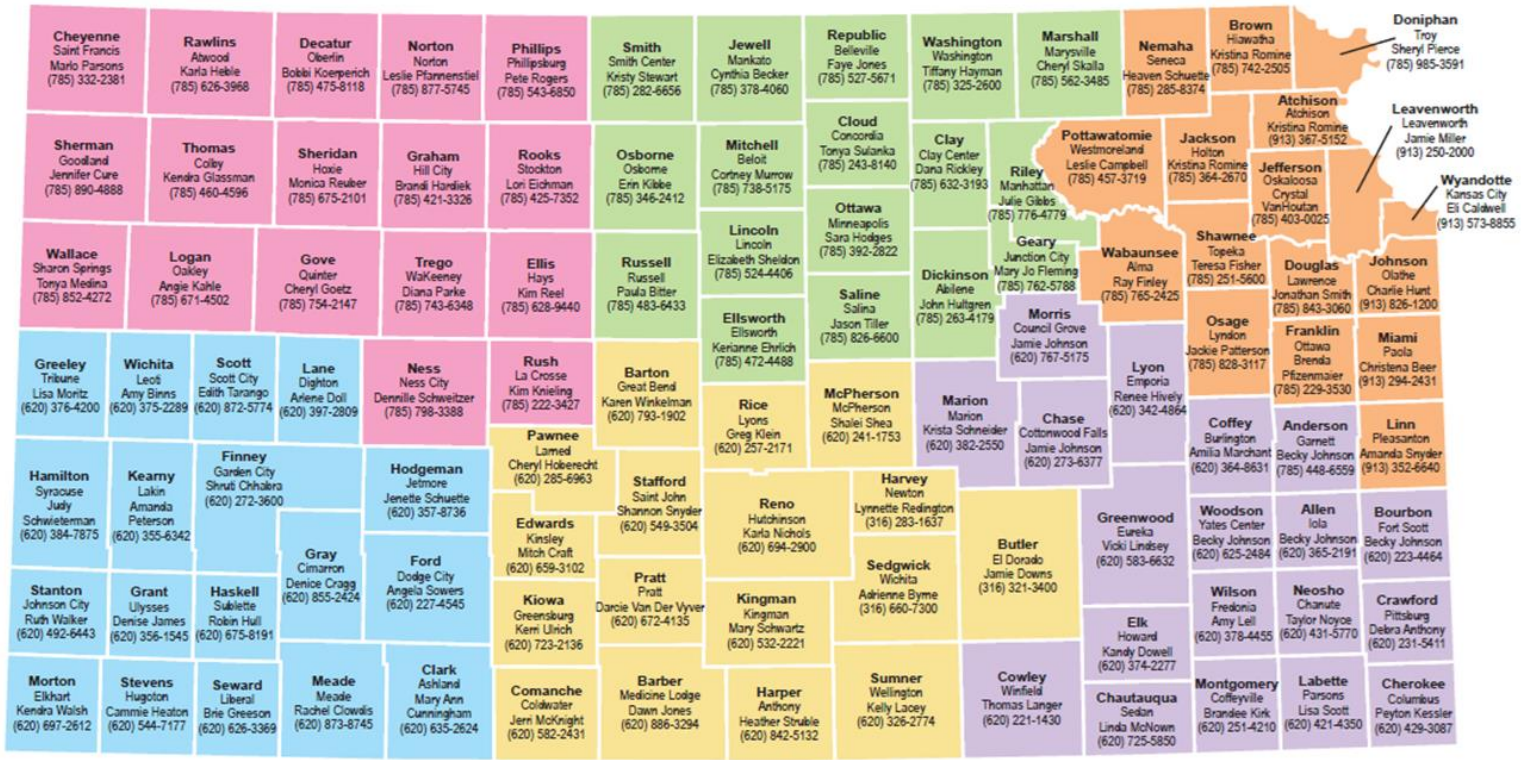
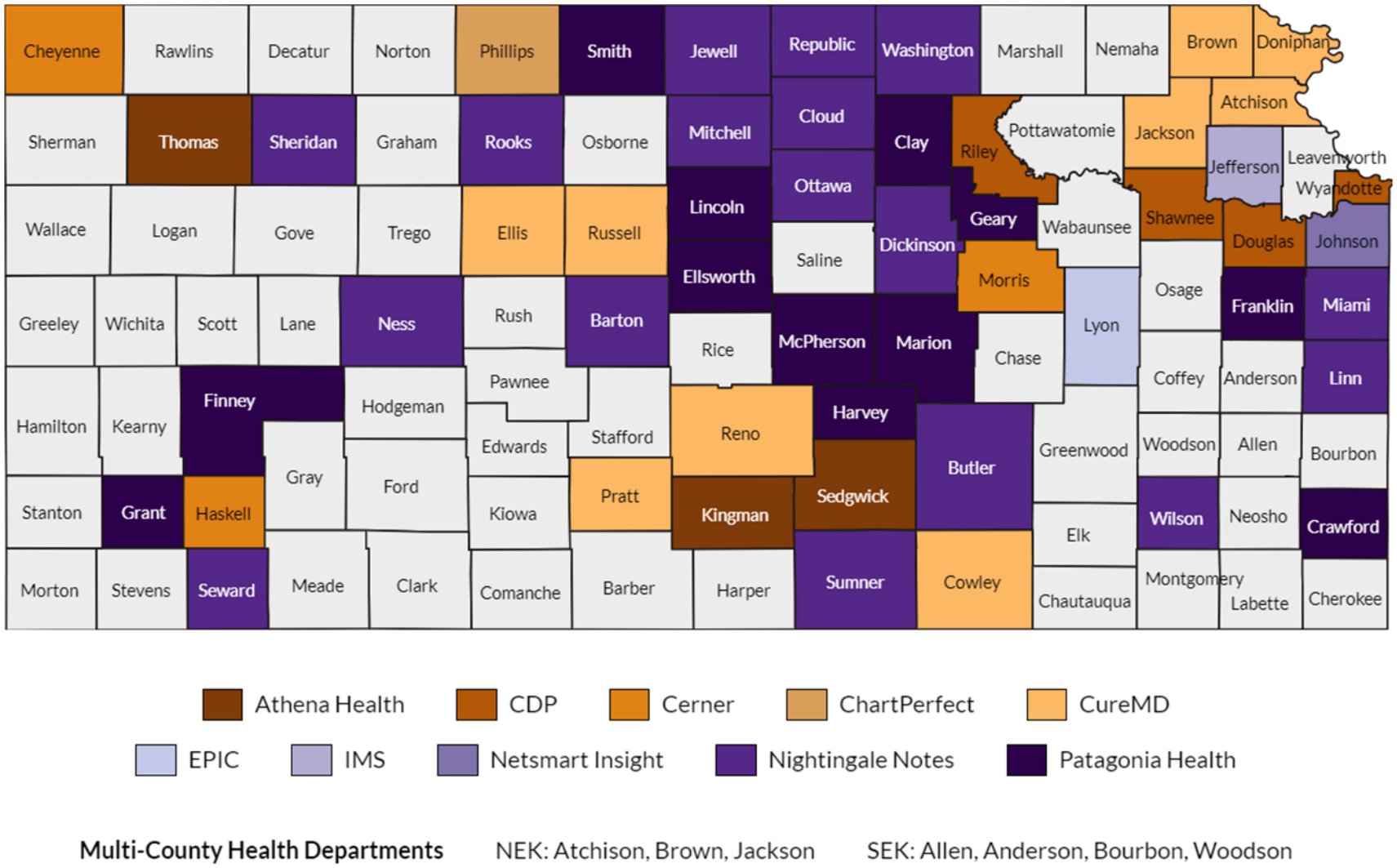


Source: https://www.kdhe.ks.gov/1801/Kansas-Regional-Public-Health-Map

EHR Platforms Used by Local Health Departments



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: Home (kmap-state-ks.us).

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 Health Plan Information (ks.gov).

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, Aetna, Sunflower and United Healthcare. 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 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 Coventry Health Care KS Preferred Health	800-624-0756	Aetna Better Health of Kansas
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 (ks.gov).

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 Home (kmap-state-ks.us). 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

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 and UHC is 365 days from the date of service
	For Sunflower, timely filing is 365 days from the notification of payment or denial (NOP).
***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. • Claim Reconsideration: 120 calendar days from the provider remittance advice/EOB. • Formal Appeal: 60 calendar days from the last notice of adverse action (reconsideration notification letter, Notice of action letter)
Sunflower State	• Submission: dependent on contract agreement. When Sunflower State is the secondary payer, claims must be received within 365 calendar days from date of the final determination of the primary payer. • Resubmission: 180 calendar days from the original date of notification of payment or denial • 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. • Claim Reconsideration: 120 calendar days from the provider remittance advice/EOB. • 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. • 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. • 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. • To submit a retrospective review online to Blue Cross Blue Shield of Kansas, go to: BCBSKS Provider Claim/Enrollment Inquiry Form • 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/COVENTRY	• Submission: 120 days from date of service. • Resubmission: 180 days from date of denial/processing • 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
- Sunflower Provider Services Department: 1-877-644-4623
- United 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: KanCare Providers Frequently Asked Questions. This site contains a contact for KDHE. KDHE should be contacted only when all other resources have been exhausted.

4.6 MCO Reconsideration Process

KMAP General Bulletin 17105

Effective May 1, 2017, 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.

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.

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
- Prior Authorizations
- Submit Prior Authorization Request
- Prior Authorization Inquiry
- Submit Service Referral
- Service Referral Search

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 Crosswalks

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

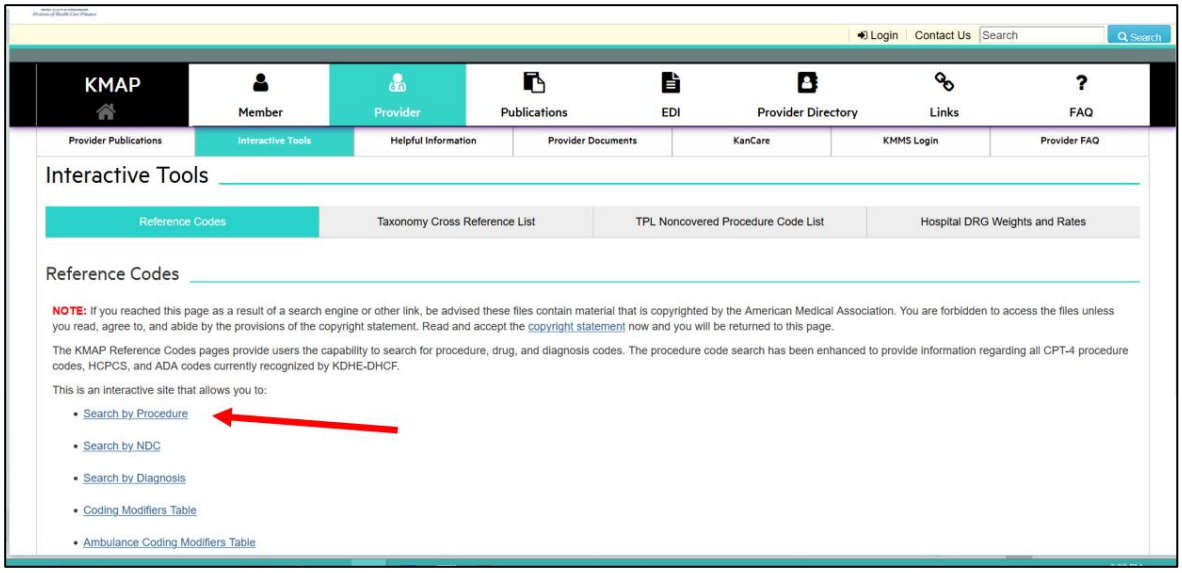
All information listed here is for reference and suggestions only. Please review all requirements for service and documentation prior to utilizing any listed CPT or ICD-10 codes.

Per KMAP General Bulleting 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.

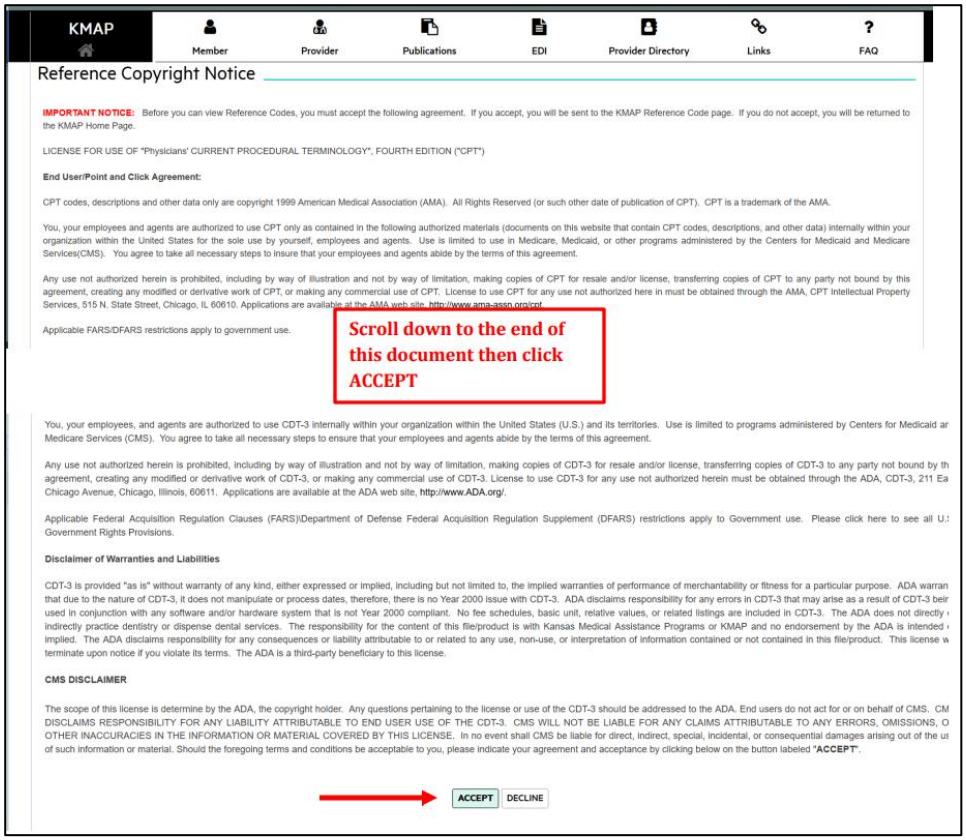
All reimbursement rates listed are accurate as of February 1, 2019. To view current reimbursement rates:

1. Go to Provider Interactive Tools (kmap-state-ks.us)

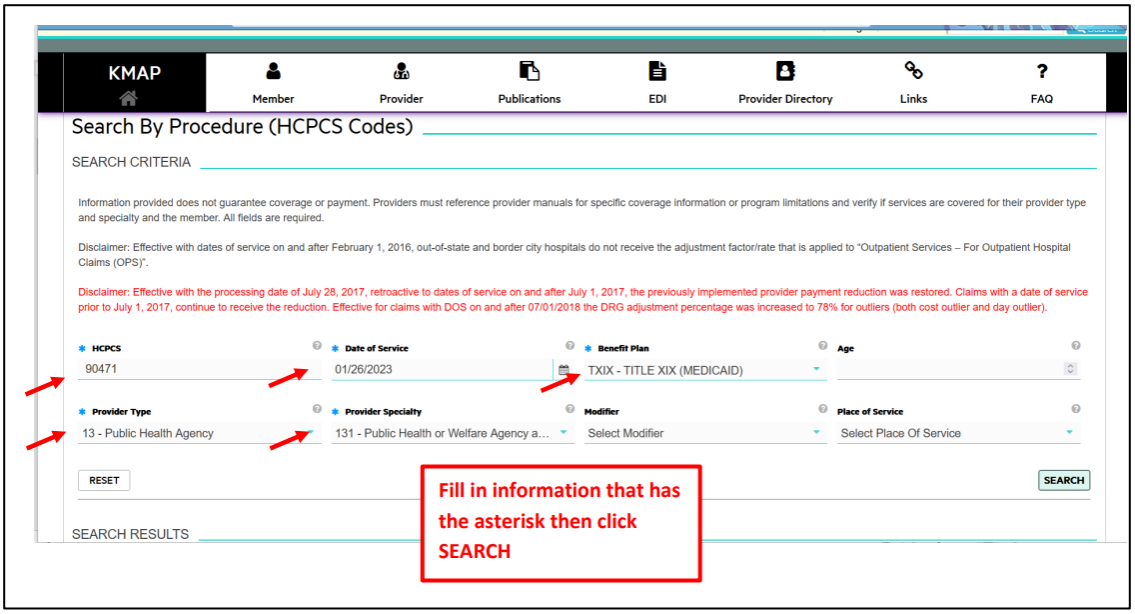
2. Select **Search by Procedure**



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



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



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 Vaccines for Children (VFC): Eligibility Criteria | 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. 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 + add on code* (not Payable through KanCare)	90461	Z23	0 -18 yrs
Immunization admin; 1 vaccine	90471	Z23	
Immunization admin; each additional vaccine + add on code*	90472	Z23	
Immunization admin, oral, nasal; 1 vaccine	90473	Z23	
Immunization admin, oral, nasal; each additional vaccine + 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	
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 + add on code*	90472	Z23	
Immunization admin, oral, nasal; 1 vaccine	90473	Z23	
Immunization admin, oral, nasal; each additional vaccine + add on code*	90474	Z23	W 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 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 2023-2024 Season

Visit Seasonal Influenza Vaccines Pricing | CMS for additional Medicare Payment Allowance information.

Manufacturer	Trade Name	Supply	Age Group	CPT	ICD-10
AstraZeneca	FluMist (LAIV4)	0.2 mL (single-use nasal spray)	2 through 49 years	90672	Z23
GSK	Fluarix (IIV4)	0.5 mL (single-dose syringe)	6 months & older	90686	Z23
	FluLaval (IIV4)	0.5 mL (single-dose syringe)	6 months & older	90686	Z23
Sanofi	Flublok (RIV4)	0.5 mL (single-dose syringe)	18 years & older	90682	Z23
	Fluzone (IIV4)	0.5 mL (single-dose syringe)	6 months & older	90686	Z23
		0.5 mL (single-dose vial)	6 months & older	90686	Z23
		5.0 mL multi-dose vial (0.25 mL dose)	6 through 35 months	90687	Z23
		5.0 mL multi-dose vial (0.5 mL dose)	6 months & older	90688	Z23
	Fluzone High-Dose (IIV4-HD)	0.7 mL (single-dose syringe)	65 years & older	90662	Z23
Seqirus	Afluria (IIV4)	5.0 mL multi-dose vial (0.25 mL dose)	6 through 35 months	90687	Z23
		5.0 mL multi-dose vial (0.5 mL dose)	3 years & older	90688	Z23
		0.5 mL (single-dose syringe)	3 years & older	90686	Z23
	Fluad (allV4)	0.5 mL (single-dose syringe)	65 years & older	90694	Z23
	Flucelvax (ccIIV4)	0.5 mL (single-dose syringe)	6 months & older	90674	Z23
		5.0 mL multi-dose vial (0.5 mL dose)	6 months & older	90756	Z23

Source: www.immunize.org/catg.d/p4072.pdf

6.8 Covid-19 Products 2023-2024 Season

Manufacturer	Trade Name	Supply	Age Group	CPT	ICD-10
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
Administration		Administration fee	All ages	90480	Z23

6.9 Respiratory Syncytial Virus (RSV) Products 2023-2024 Season

Manufacturer	Trade Name	Supply	Age Group	CPT	ICD-10
Pfizer	Abrysvo	0.5 mL vial	Pregnant women Ages 9 - 55 All – Ages 60 and over	90678	Z23
GSK	Arexvy	0.5 mL vial	60 and over	90679	Z23
Sanofi	Beyfortus	0.5 mL syringe		90380	Z23
	Beyfortus	1.0 mL syringe		90381	Z23

For additional information on age groups and delivery, see recommendations from manufacturers.

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

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.

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)

KBH Billing Guidance: KBH screening providers must bill each of the 12 components **separately**; When doing a Kan-Be-Healthy and immunizations the same visit, you need to add Modifier 25 to the KBH in order 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.

All KBH screenings must include minimum documentation of the following 12 components. These must be billed separately.

Note: The EP modifier became strictly informational beginning November 1, 2018. It is not able to be used to bundle a payment. Components must be billed separately.

- 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 screenSee Appendix 11.12 for KBH Specific Billing Reference

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	D1206	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
Diagnosis Codes ICD-10		
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
Smoking (tobacco). *Please see* Billing Guide for Tobacco Screening and Cessation (lung.org) *or the appropriate code.*		O99.330-O99.335
Supervision of other high risk pregnancy		009.899
Threatened spontaneous abortion		020.0

7.5 KanCare Specific Kan Be Healthy Components

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), Z77011 (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, 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
Topical Fluoride Varnish	D1206	Z01.20, Z01.21

7.6 Lactation Counseling

Medicaid		
Service Description	HCPCS Code	ICD-10 Code
Lactation classes, non-physician provider, per session	S9443	
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 (KMAP Bulletin 18189) - 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).

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.

DISCLAIMER: Not all payers cover dispensing or administrative fees. Additionally, not all payers cover multiple E

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 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
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
Counseling/Interventions		
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; 11 minutes and up	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.

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); 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. 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 **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 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

99203
99213
	Low	Low
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(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
99214
	Moderate	Moderate
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• 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
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	High
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• 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
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• 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					
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				
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; 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; 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	Immunization Schedules | CDC
Advance Beneficiary of Notice and Instructions	MLN006266 – Medicare Advance Written Notices of Non-coverage (cms.gov)
Aetna Better Health of KS	For Providers | Aetna Better Health of Kansas
Aetna Medicare	Resources & Support for Health Care Providers | Aetna
Aetna Better Health of KS: Grievance, Resubmission-Reconsideration, Appeals timelines and detailed information	Grievances & Appeals | Aetna Better Health of Kansas
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	Healthcare Technology & Business Solutions Company | Change Healthcare
Change HealthCare Claims & Denials Advisor	Change HealthCare Claims & Denials Advisor
Cigna	Cigna Healthcare | Health Insurance, Dental Plans & Medicare
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)
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 Manuals and Guides	Provider Manuals, Forms and Resources | Sunflower Health Plan
Sunflower State Health Plan Provider Representative Contacts and Territory Map	Kansas Provider Resources | Kansas Medicaid | Sunflower Health Plan
Sunflower State 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	Resources and tools for providers and health care professionals | UHCprovider.com
Washington Publishing Company	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: • Level I - American Medical Association's Current Procedural Terminology (CPT) codes. • 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. • 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: • **Medicare Part A** - Hospital coverage • **Medicare Part B** - Physicians visits and outpatient procedures • Medicare Advantage Plans, sometimes called **Medicare Part C** or MA Plans, are offered by private companies approved by Medicare. • **Medicare Part D** - Medicare insurance for prescription drug costs for anyone enrolled in Medicare Part A or B.

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.

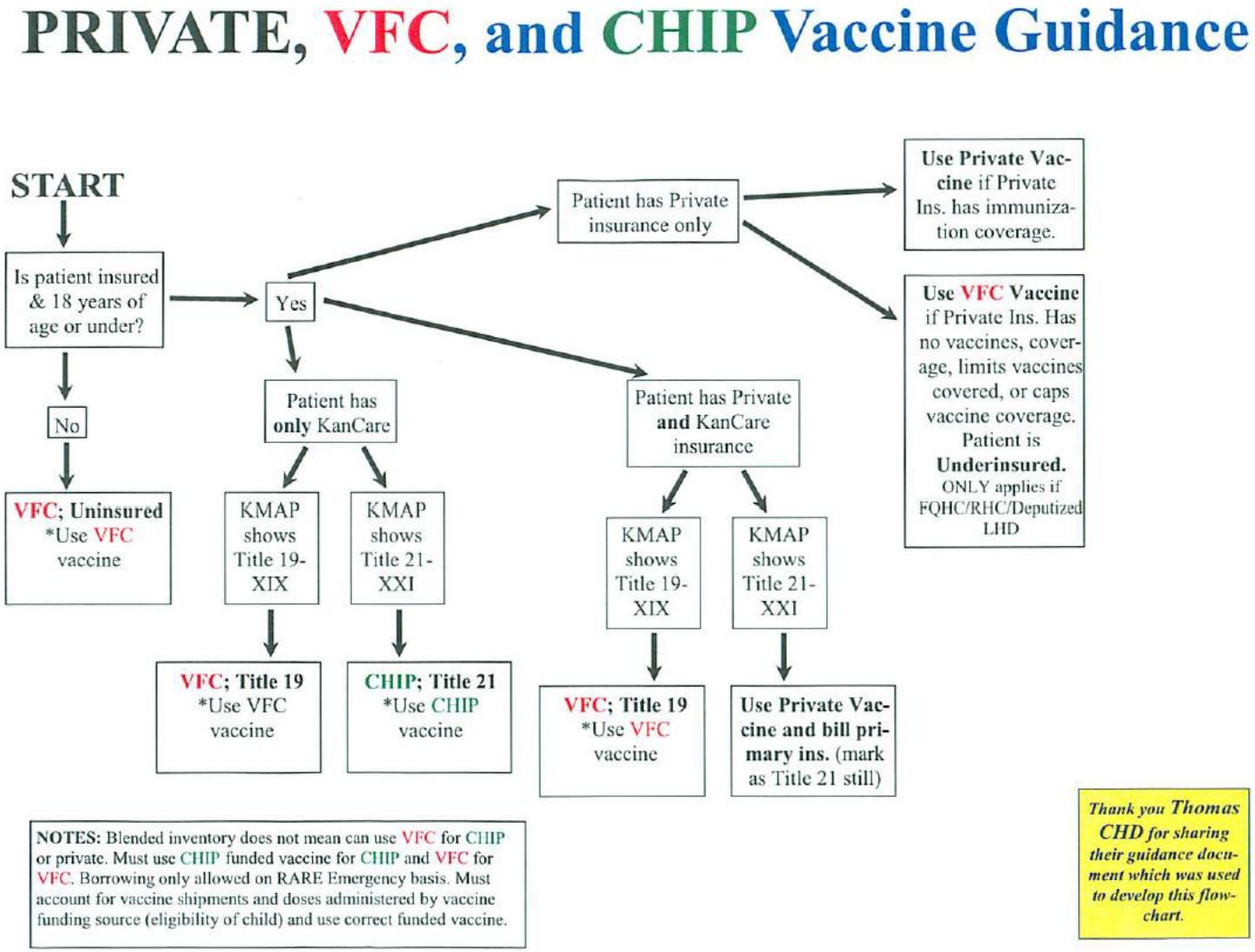
	Outpatient	Typically treatment in a physician's office, clinic, or day surgery facility lasting less than one day.
	Patient Responsibility	The amount a patient is responsible for paying that is not covered by the insurance plan.
PCP	**Primary Care Provider**	Usually the physician who provides initial 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.

	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)



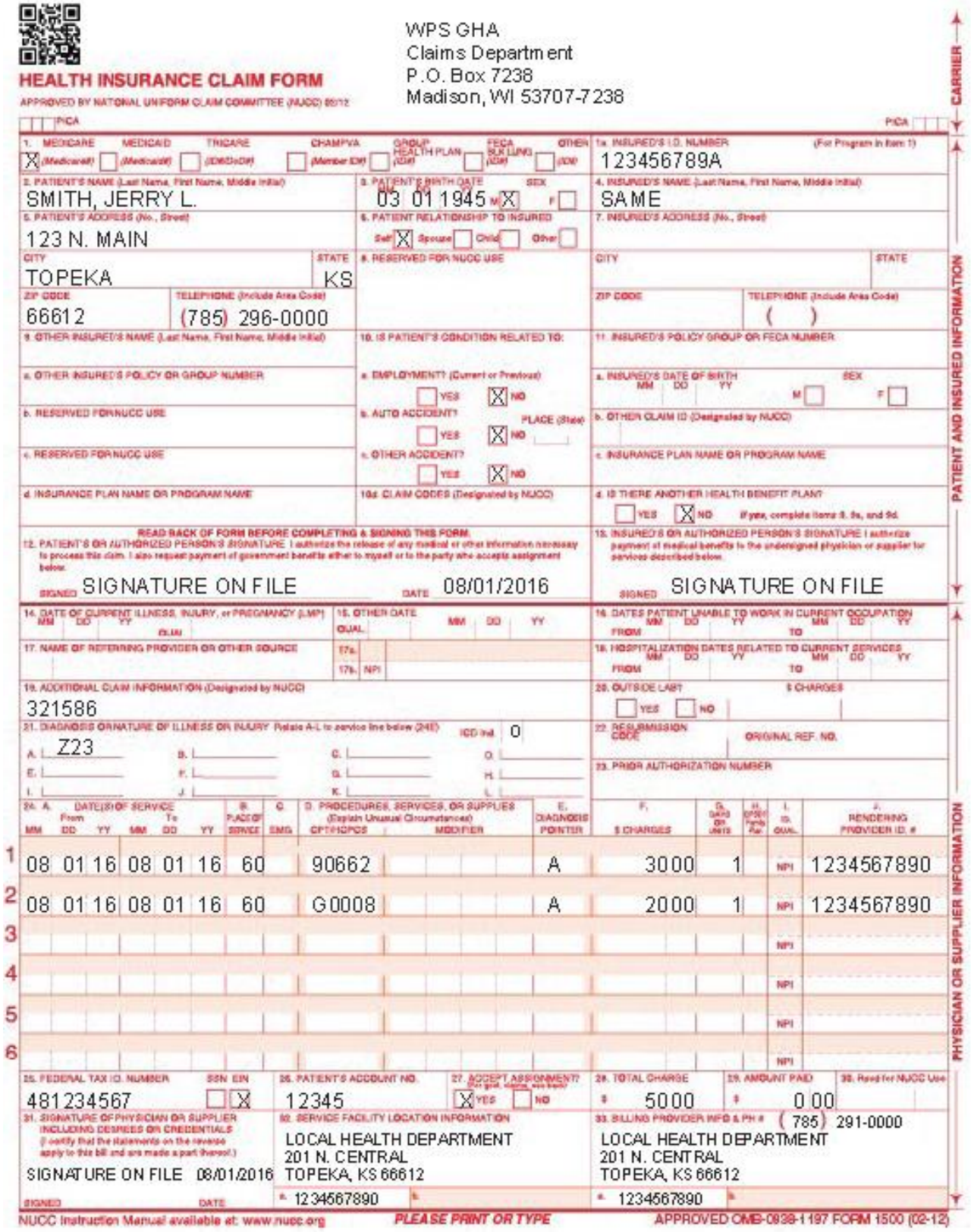
11.7 Common EDI Payer ID's

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. 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 Pre-Enrollment is required for Electronic Remittance Advice.
Champus	99726		Customer Service: (877) 988-9378. Coverage: KS, NE. Pre-Enrollment is required for Electronic Remittance Advice.
Champva	99726		
Cigna	62308	Y	Customer Service: (800) 468-3510 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 Pre-Enrollment is required for Electronic Remittance Advice .
Delta Dental of Kansas	CDKS1		
First Health Network	73159	N	
Harrington Health	62061		
Humana	61101	Y	Customer Service: (800) 448-6262 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 State Health Plan - KANCARE	68069	Y	Customer Service: (866) 595-8133 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 Pre-Enrollment is required for Electronic Remittance Advice.
UMR	39026	Y	Customer Service: (877) 233-1800 Pre-Enrollment is required for Electronic Remittance Advice
United Healthcare	87726	Y	Customer Service: (866) 633-2446 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)



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: 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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI:

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

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:

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	3000	1		NPI	1234567890
2 08 01 16	08 01 16	60		G0008		A	2000	1		NPI	1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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: $ 5000

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

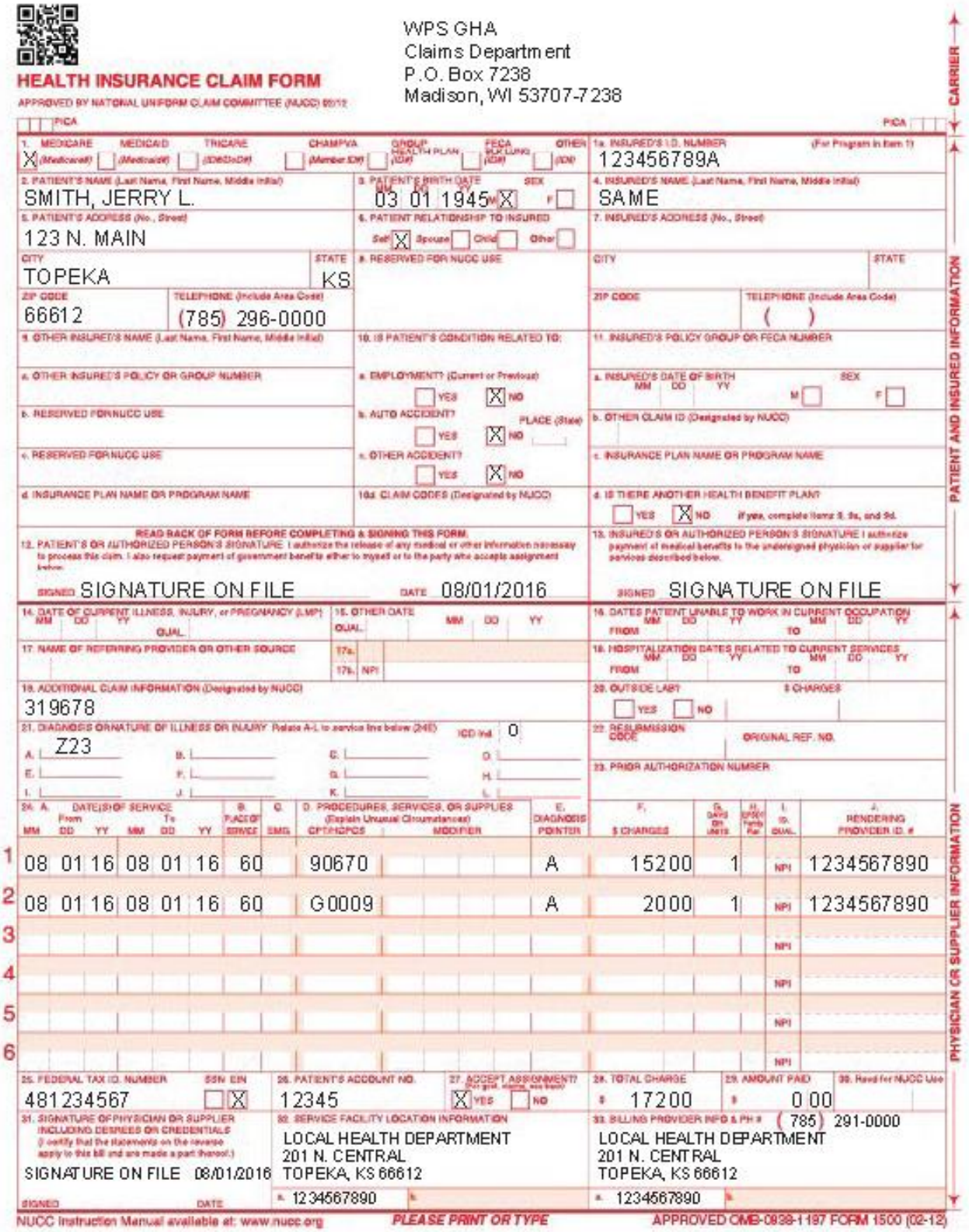
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): SIGNATURE ON FILE 08/01/2016 SIGNED DATE

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)

Medicare, Pneumonia Shot (Prevnar 13)



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	1a. INSURED'S I.D. NUMBER: 123456789A
2. PATIENT'S NAME: SMITH, JERRY L.	3. PATIENT'S BIRTH DATE: 03 01 1945 SEX: M X F
4. INSURED'S NAME: SAME	
5. PATIENT'S ADDRESS: 123 N. MAIN	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS:	
CITY: TOPEKA	STATE: KS
8. RESERVED FOR NUCC USE	CITY: STATE:
ZIP CODE: 66612	TELEPHONE: (785) 296-0000
ZIP CODE:	TELEPHONE: ( )
9. OTHER INSURED'S NAME:	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: 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 MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
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	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. Z23 B. C. D. E. F. G. H. I. J. K. L.	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		90670		A	15200	1		NPI	1234567890
2	08 01 16	08 01 16	60		G0009		A	2000	1		NPI	1234567890
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX ID. NUMBER: 481234567 SSN EIN: EIN X	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE: $ 17200	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.	

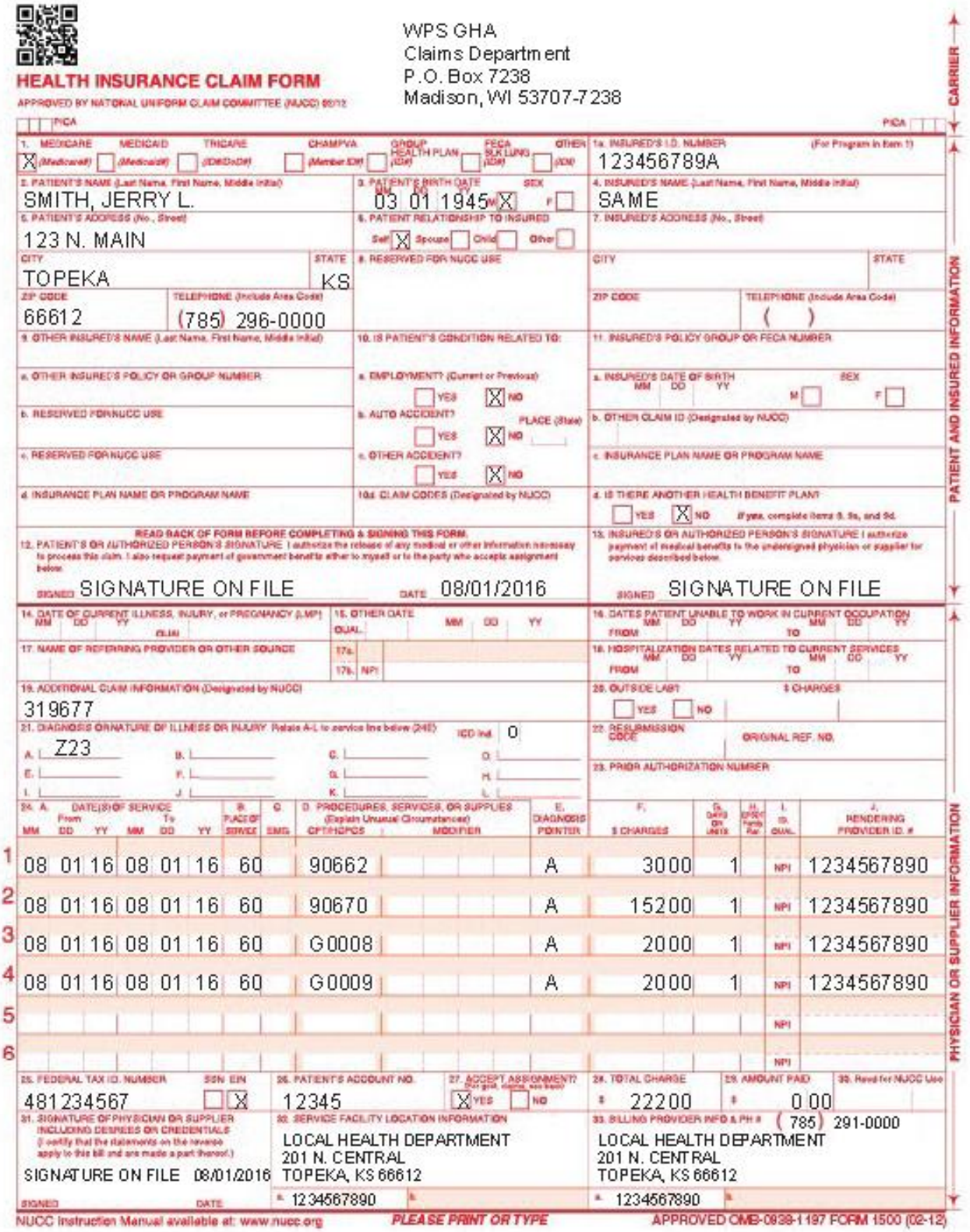
NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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



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, 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 MM DD YY FROM / TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / 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	22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. Z23 B. C. D. E. F. G. H. I. J. K. L.	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	3000	1		NPI	1234567890
2	08 01 16	08 01 16	60		90670		A	15200	1		NPI	1234567890
3	08 01 16	08 01 16	60		G0008		A	2000	1		NPI	1234567890
4	08 01 16	08 01 16	60		G0009		A	2000	1		NPI	1234567890
5											NPI	
6											NPI	

25. FEDERAL TAX ID. 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: $ 22200	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.

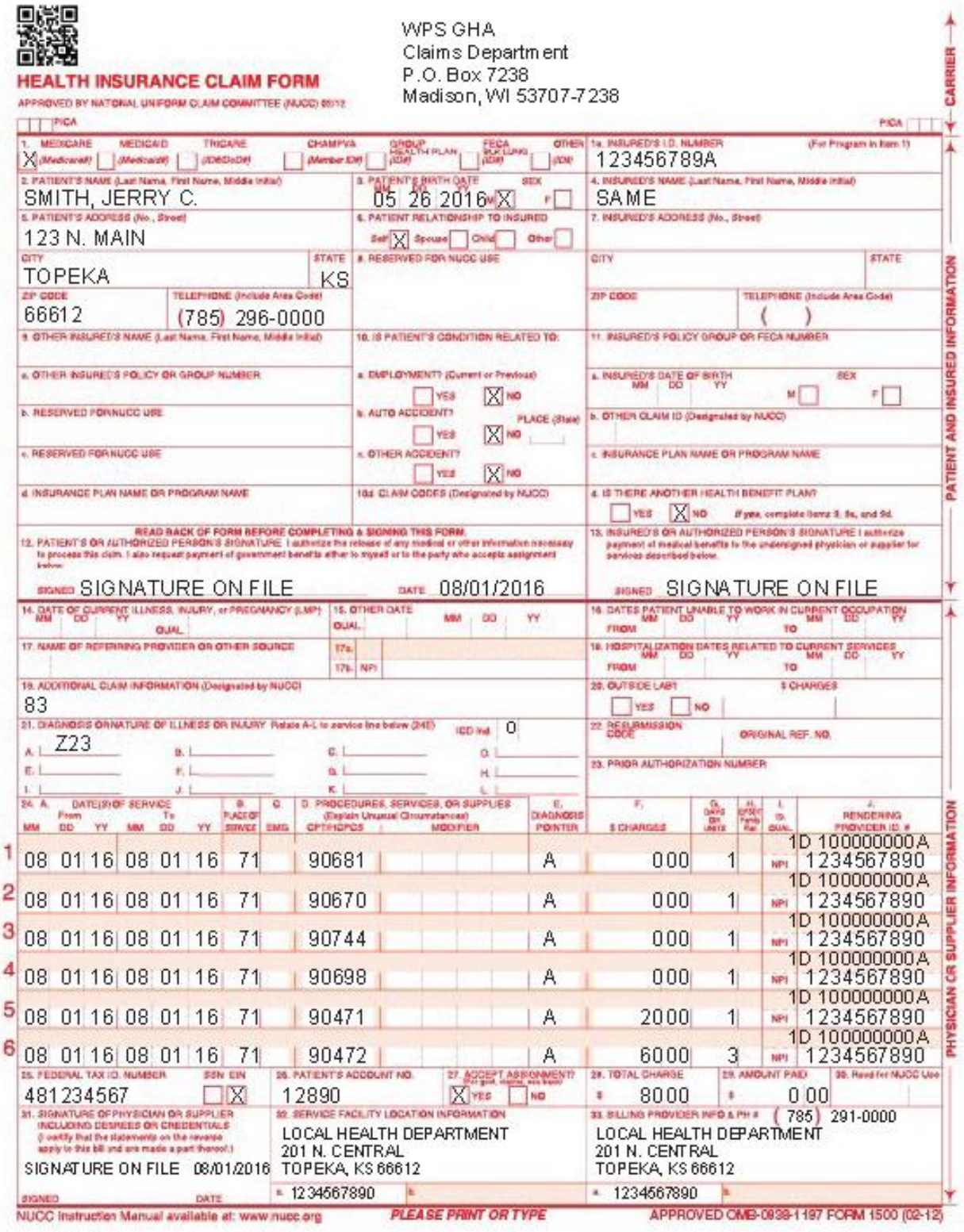
CARRIER

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)

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

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 C.

3. PATIENT'S BIRTH DATE: 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 ( ) 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: MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 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 (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	71		90681		A	000	1		NPI	1D 100000000A 1234567890
2	08 01 16 | 08 01 16	71		90670		A	000	1		NPI	1D 100000000A 1234567890
3	08 01 16 | 08 01 16	71		90744		A	000	1		NPI	1D 100000000A 1234567890
4	08 01 16 | 08 01 16	71		90698		A	000	1		NPI	1D 100000000A 1234567890
5	08 01 16 | 08 01 16	71		90471		A	2000	1		NPI	1D 100000000A 1234567890
6	08 01 16 | 08 01 16	71		90472		A	6000	3		NPI	1D 100000000A 1234567890

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 481234567 | SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: 12890

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

28. TOTAL CHARGE: $ 8000

29. AMOUNT PAID: $ 000

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

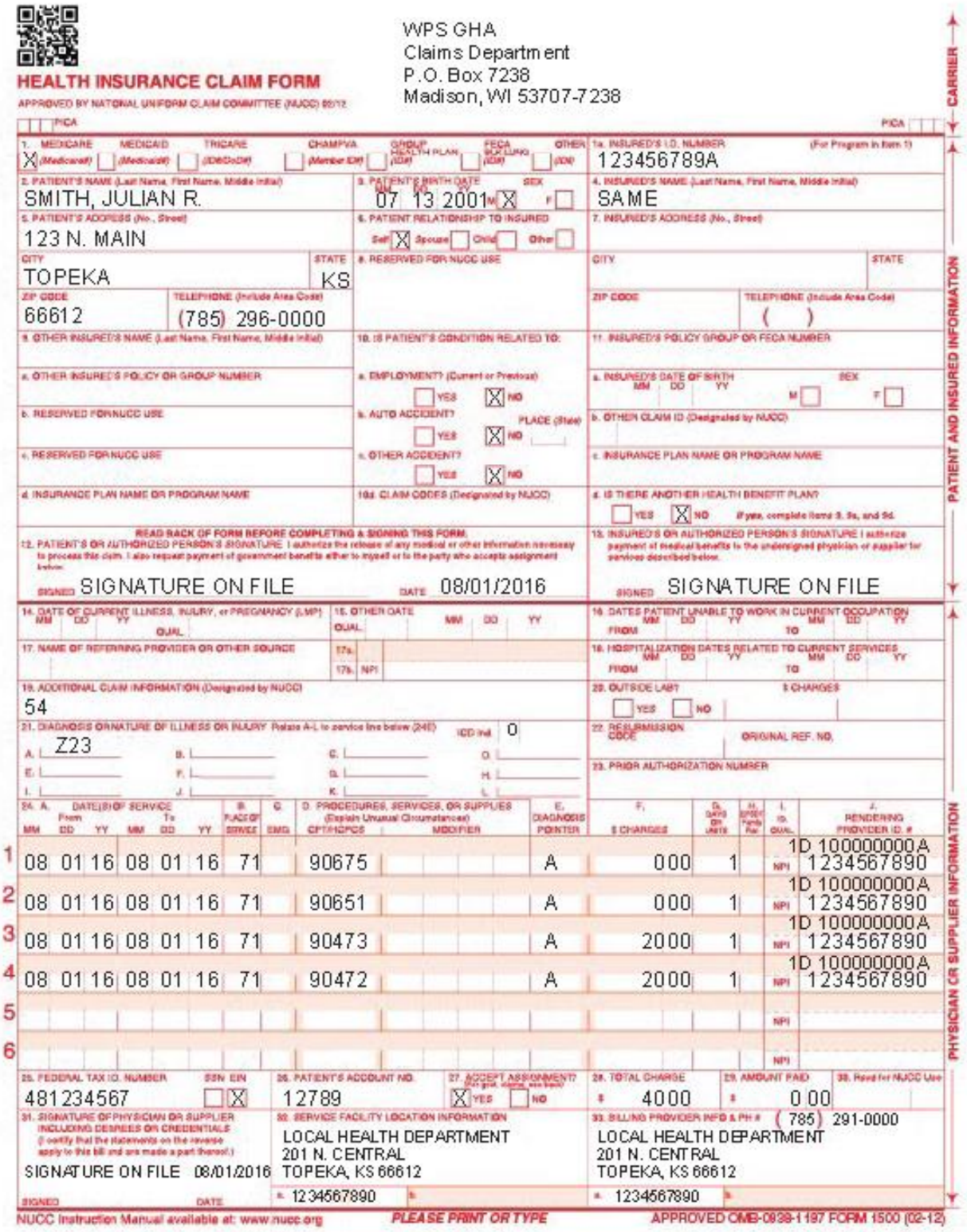
a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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: 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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY 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 (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	71		90675		A	000	1		1D 100000000A NPI 1234567890
2	08	01	16	08	01	16	71		90651		A	000	1		1D 100000000A NPI 1234567890
3	08	01	16	08	01	16	71		90473		A	2000	1		1D 100000000A NPI 1234567890
4	08	01	16	08	01	16	71		90472		A	2000	1		1D 100000000A NPI 1234567890
5															NPI
6															NPI

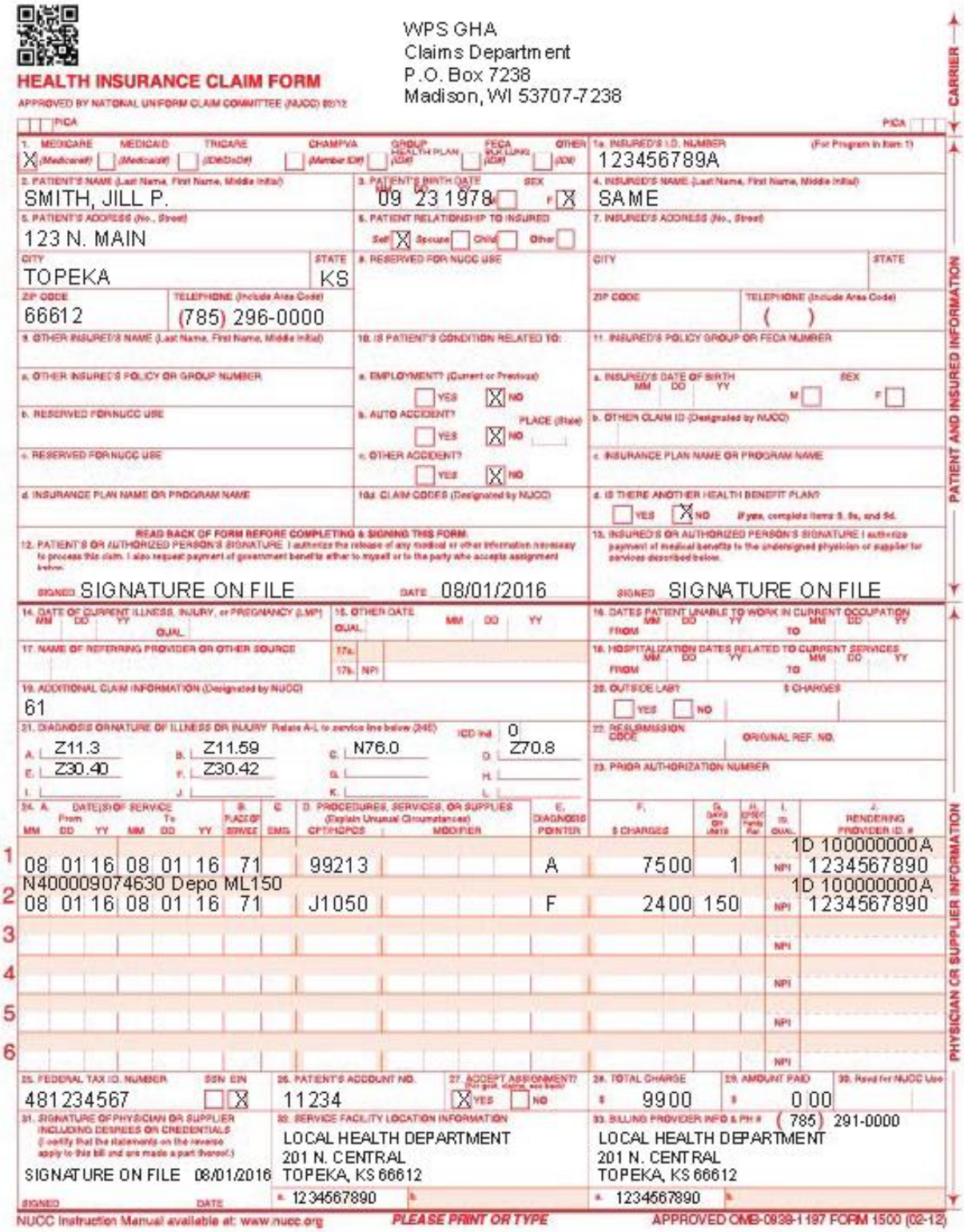
25. FEDERAL TAX I.D. NUMBER: 481234567 SSN EIN X
26. PATIENT'S ACCOUNT NO.: 12789
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO
28. TOTAL CHARGE: $ 4000
29. AMOUNT PAID: $ 0 00
30. Rsvd for NUCC Use

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

1. MEDICARE (Medicare#) X	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 Spouse Child Other
7. INSURED'S ADDRESS	
CITY: TOPEKA	STATE: KS
8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE: 66612	TELEPHONE: (785) 296-0000
ZIP CODE / TELEPHONE	
9. OTHER INSURED'S NAME	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 / SEX	
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) QUAL	15. OTHER DATE QUAL
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 (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	71		99213		A	7500	1		NPI	1D 100000000A 1234567890
2 N400009074630 Depo ML150 08 01 16	08 01 16	71		J1050		F	2400	150		NPI	1D 100000000A 1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX ID. NUMBER: 481234567 SSN EIN	26. PATIENT'S ACCOUNT NO.: 11234	27. ACCEPT ASSIGNMENT? YES X NO	28. TOTAL CHARGE: $ 9900	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.		

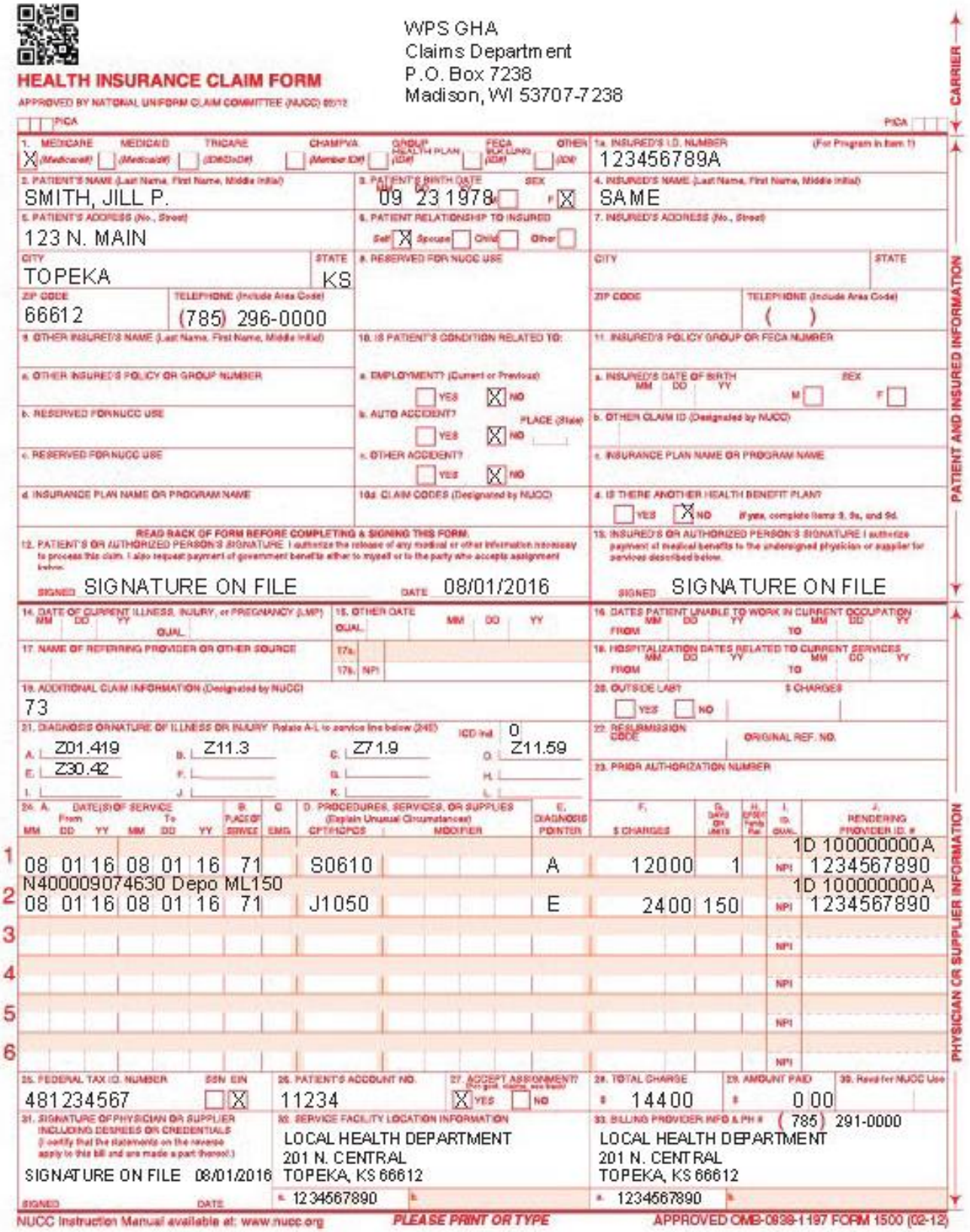
NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Exam and Depo



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 [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: 09 23 1978 SEX: 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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 73

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. Z01.419 B. Z11.3 C. Z71.9 D. Z11.59
E. Z30.42 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	71		S0610		A	12000	1		NPI	1D 100000000A 1234567890
2	N400009074630 Depo ML150 08 01 16	08 01 16	71		J1050		E	2400	150		NPI	1D 100000000A 1234567890
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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

26. PATIENT'S ACCOUNT NO.: 11234

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

28. TOTAL CHARGE: $ 14400

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)

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 4 – 4 – 2	09999 – 9999 – 99 5 – 4 – 2	0002-7597-01	00002-7597-01	00002759701
99999 – 999 – 99 5 – 3 – 2	99999 – 0999 – 99 5 – 4 – 2	50242-040-62	50242-0040-62	50242004062
99999 – 9999 – 9 5 – 4 – 1	99999 –9999 – 09 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			**Model 2: Blood is drawn and laboratory tests are performed in the physician's practice**		
Service	**CPT Code**	**Reimbursement**	**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, for diagnostic or therapeutic purposes (not be used for routine venipuncture)	36410	$13.90
Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture	36406	$13.63	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
Venipuncture, 3 years or older, necessitating physician's skill, not to be used for routine venipuncture	36410	$13.90	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 (https://www.kmap-state-ks.us/public/kan%20be%20healthy%20main.asp) as well as the AAP Manual (https://www.aap.org/en-us/Documents/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?

Webinars are held monthly by the Mid-America MHTTC (HHS Region 7). Topics focus on specific SDoH categories and archived webinars are available for review. Information can be found here, Context Clues: Using Social Determinants of Health (SDOH) to Enhance Treatment | Mental Health Technology Transfer Center (MHTTC) Network (mhttcnetwork.org) In the future, webinars will be available on KSTrain.

How are the Z-Codes Organized?

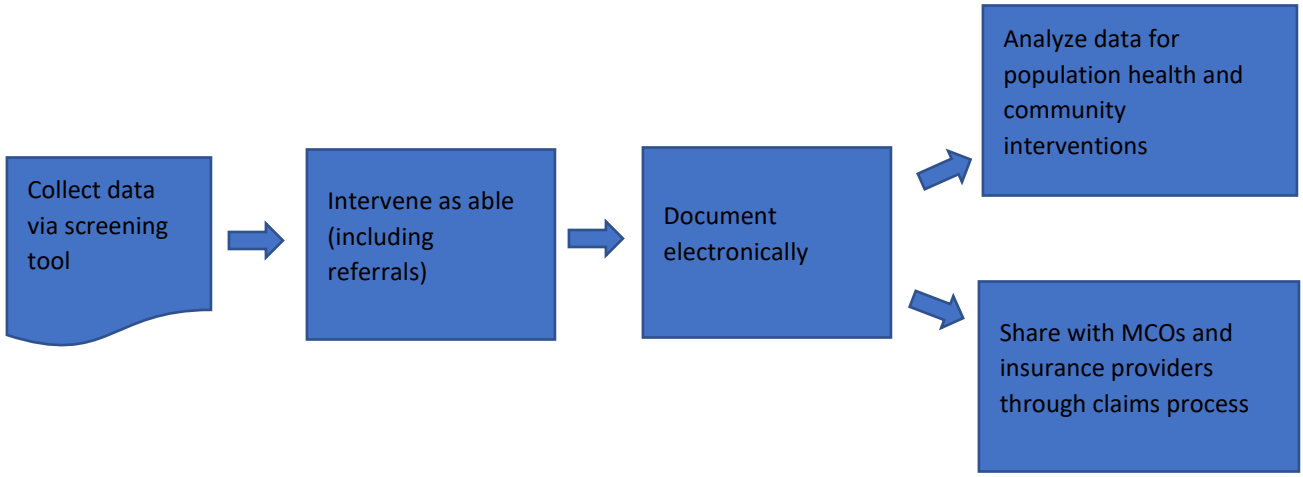
The full list of Z-Codes is numerous. They are organized into categories ranging from Z00 to Z99, with multiple individual codes listed within each category. Z-Codes related to Social Determinants of Health are in categories numbering Z55 to Z91 as listed below.

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.