Louisiana DHH Medicaid

Cross-Reference for the 837P and KM-3 KIDMED Billing Form

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Prepared By:
Shannon L. Clark, HIPAA Operations Team Lead
Mike Crum, HIPAA Analyst

KM-3 KIDMED BILLING FORM TO 837P CROSSWALK

PURPOSE

This document is intended for vendors, billing agents, and clearinghouses (VBCs) to assist them with formatting specific segments on the 837P EDI transaction with data currently required on the paper KM-3 KIDMED billing form that is not currently accommodated on the standard 837P transaction. This document is intended to supplement information contained in the following documents:

- **HIPAA 837P Implementation Guide**, which contains detailed information on 837P segment structures, and
- **LA Medicaid 837P KIDMED Companion Guide**, which further defines LA Medicaid billing requirements and lists specified data values for 837P transactions.

On the following pages are a KM-3 form sample and a crosswalk of these specific KM-3 data fields and their corresponding 837P loop identifiers and segment values/examples. Any questions regarding set up of the 837P for these specific KM-3 data fields should be directed to HIPAA EDI Support at 225.237.3318 or via email at *hipaaedi@unisys.com (note: the leading asterisk is part of the email address).

KIDMED Screening Services (KM-3) Form Sample

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. ☐ ORIGINAL ☐ ADJUSTMENT ☐ VOID
2. REASON 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
( ) -	( ) -		

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN						
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT						

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? ☐ YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. ☐ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES ☐ NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO		G.	
H. PHONE NO. ( ) -		I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO	

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO		G.	
H. PHONE NO. ( ) -		I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO	

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO		G.	
H. PHONE NO. ( ) -		I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO	

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:

- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

02/03
KM-3

36. SIGNATURE OF PROVIDER 37. DATE

KM3 KIDMED Billing Form and 837P Crosswalk

KM3 FORM FIELD NO.	KM3 FORM FIELD NAME	837P LOOP IDENTIFIER	837P SEGMENT VALUES AND EXAMPLES
6	Site No.	Loop 2010AA	REF01=G5 REF02=three digit site number
21	Patient Home Phone	Loop 2300	Example: K3*PAT$2255551212$2255551234~
22	Patient Work Phone	Loop 2300	Example: K3*PAT$2255551212$2255551234~
23	Parent/Guardian Last Name	Loop 2010BC	NM103 – Max 30 chars
24	First Name (Parent/Guardian)	Loop 2010BC	NM104 – Max 25 chars
29	Are Immunizations Complete and Current For This Age Patient?	Loop 2300	If response is 'Yes': K3*IM$Y~ Example, if response is 'No': K3*IMNA~ *(Note: For 'No', 1 of 3 reason codes must be specified)*
30	If Immunizations Are Not Complete and Current as of This Screening, Check Reason: A. Medically Contraindicted B. Parental Refusal C. Off Schedule	Loop 2300	If response is 'Yes': K3*IM$Y~ Example, if response is 'No': K3*IMNA~ *(Note: For 'No', 1 of 3 reason codes must be specified)*
31	Are There Suspected Conditions?	Loop 2300	If response is 'No': K3*SC$N~ Example, if response is 'Yes': K3*SCYAO$EI~ *(Note: For 'Yes', multiple combinations of condition codes and type of referral codes may be included)*
32	Undercare Referral Offsite Referral In-House	Loop 2300	If response is 'No': K3*SC$N~ Example, if response is 'Yes': K3*SCYAO$EI~ *(Note: For 'Yes', multiple combinations of condition codes and type of referral codes may be included)*
33	Referrals for Suspected Conditions	Loop 2300	Example for first referral: K3*R1A040127$REASON$XYZCLINIC$$2251234567~
34	Referrals for Suspected Conditions	Loop 2300	Example, if sending a second referral: K3*R2E040130$REASON$SELF$$2251234567~
35	Referrals for Suspected Conditions	Loop 2300	Example, if sending a third referral: K3*R3V040131$REASON$SMITH$JOHN$2251234567~