

Appendix 1 - NPI Record Sample



The information for the Organization you selected is displayed. The NPI Registry data was last updated on **05/07/2013**.

NOTE: Some health care providers reported SSN or IRS ITIN information in sections of the NPI application that contain information that is required to be disclosed under FOIA. For example, an incorporated individual may have reported an SSN as the EIN of the corporation. To protect the privacy of this individual, we have temporarily suppressed the EIN, and we have made every attempt to locate and remove SSN and IRS ITIN information from being displayed in any of the other information provided below.

Organization Information:

Organization Name (LBN): CITY OF OAK CREEK
Other Name: OAK CREEK HEALTH DEPARTMENT
EIN: <temporarily suppressed>
Organization Subpart: NO

Authorized Official Information:

Name: JUDITH A PRICE BSN, MS
Title/Position: COMMUNITY PUBLIC HEALTH OFFICER
Phone Number: 4147686525

NPI Information:

NPI: 1114056322
Entity Type: 2-ORGANIZATION
Enumeration Date: 03/05/2007
Last Update Date: 07/08/2007
Replacement NPI:
Deactivation Date:
Reactivation Date:

Provider Business Mailing Address:

Address: 8640 S HOWELL AVE
 OAK CREEK, WI 53154-2918
Phone Number: 4147686525
Fax Number: 4147685866

Provider Business Practice Location Address:

Address: 8640 S HOWELL AVE
 OAK CREEK, WI 53154-2918
Phone Number: 4147686525
Fax Number: 4147685866

Organization Taxonomy:

Primary Taxonomy	Selected Taxonomy	State	License Number
YES	251K00000X - PUBLIC HEALTH OR WELFARE		

Other Provider Identifier:

Issuer	Number	State	Issuer
MEDICARE ID-TYPE UNSPECIFIED	82960	WI	PROVIDER NUMBER



Appendix 2 – Sample Letter of Intent

<Today's date>

<Payer name>

Attention: <a specific name or Provider Relations Manager>
123 Main Street
Anywhere, WI 53XXX

SUBJECT: Letter of Intent for Agreement between <Agency Name> and <payer name>.

<Agency Name> requests consideration to become a network immunization provider with <payer name>. Effective October 1, 2012, the Centers for Disease Control and Prevention (CDC) began restricting the use of federally funded vaccine for the immunization of insured persons. As you are aware, the Patient Protection and Affordable Care Act of 2010 only requires a payer to waive cost-sharing for immunizations if the provider is a network provider.

<Agency Name> is able to provide your members, throughout <name> County, with the following ACIP recommended immunizations:

Hepatitis B (HepB)	Quadrivalent Meningococcal Conjugate vaccine (MCV4)
Diphtheria, tetanus and pertussis (DTaP)	Quadrivalent Meningococcal Polysaccharide Vaccine (MPSV4)
Haemophilus influenzae , type b (Hib)	Tetanus (Td)
Inactivated Polio Virus (IPV)	Tetanus, pertussis (Tdap)
Pneumococcal Conjugate Vaccine (PCV)	Pneumococcal Polysaccharide Vaccine (PPV)
Measles, Mumps, Rubella (MMR)	Human Papillomavirus (HPV)
Varicella	Rotavirus
Hepatitis A (HepA)	Herpes zoster (aka: shingles)
Influenza, inactivated	
Live, Attenuated Influenza Vaccine (LAIV) - intranasal	

Our claims would be for the vaccine, which will be purchased with private funds, and administration.

<Agency Name> is required to report all immunizations to the Wisconsin Immunization Registry. This data is then readily accessible to the member's PCP, which has been verified to meet the NCQA Meaningful Use Measure 9 for Patient Centered Medical Home accreditation. This data is also available for HEDIS reporting.

<Agency Name> follows the Wisconsin Immunization Program's protocol for providing immunizations. Our medical director, <insert MD name>, provides oversight of the services and the following health professionals actually render the services:

Jane Doe, RN, ANP
Betsy Smith, RN, BSN
Susan Carter, PA

Billing information:

Agency Name
Street Address
City, WI, zip

NPI = XXXXXXXXXXXX
TIN = XX-XXXXXXXX

If you have questions, please do not hesitate to call me at XXX-XXX-XXXX.

Respectfully submitted,

Jane/John Doe
<Title of signer>
<Agency name>



Appendix 3 - CAQH UPD – application process

Council for Affordable Quality Healthcare (CAQH) Universal Provider DataSource Application Process:
Full Instructions found at <https://upd.caqh.org/OAS/UPDQuickReferenceGuide20120820.pdf>
A checklist can be found on the last page of this appendix.

The Universal Provider DataSource (UPD) is the database operated by CAQH that stores provider credentialing information. Once you have complete an initial application, you can use the same application for all other payers who utilize the UPD. This saves you from having to resubmit the same information to different payers.

There is no cost to the provider to use the UPD. However, your initial application must be sponsored by a participating payer. You can access the current payer list at <http://www.caqh.org/participatingorgs.php> or call the CAQH Support Desk at 1-888-599-1771.

Application Process

You may complete a credentialing application in CAQH using one of the following methods:

Online: (Recommended) The online credentialing application can be accessed at <https://upd.caqh.org/oas/>. Click on the “Resources” page and select “Login to the Universal Provider Database”.

Fax: If you are a new provider to CAQH, you may choose to fax your application to CAQH at (866) 293-0414.

UPD Navigation

• Turn Off Computer’s Pop-up Software

Personal computer pop-up software may prevent online users from accessing certain UPD features including the “add” function that allows addition of multiple training affiliations, CMEs and license information.

• Audit Feature

Before or after data entry, select the “Audit” button at the bottom of each page. This highlights the required fields that must be entered in the database for an application to be considered complete verses those fields that are optional. A red asterisk “*” will appear next to required fields. Use of this feature reduces completion time.

• Use the “Back” and “Next” Buttons at the Bottom of Each Page

Use the “Back” and “Next” buttons on the bottom of the page to navigate backward or forward within the application. Do not use the “Back” button on your Internet navigation toolbar that controls your internet session, as it may terminate your UPD session.

Security

CAQH is committed to keeping physician information in a confidential and secure system. The UPD fully complies with all laws and regulations relating to the privacy of individually identifiable health information. A password-protected Web site ensures that only authorized medical practice staff have access to submit or update credentialing information. CAQH uses industry-leading technology to protect providers credentialing data and the privacy of system users, including:

- redundant firewalls that protect all network traffic
- secure Internet access to application screens
- secure 128-bit Secure Socket Layer (SSL) encryption
- automatic encoding of all information exchanges
- routine tape back-ups, stored off-site, to protect all volatile system data

For more information related to security, privacy or confidentiality, go to <https://upd.caqh.org/oas/>.

Demographic Changes

Not all payers use CAQH for demographic changes such as a change in billing address. Questions regarding plan-specific procedures should be directed to a health plan’s provider enrollment department.

Appendix 3 - CAQH UPD – application process

UPD Standard Notifications

The UPD system generates standard notifications to a provider when the application is complete, missing information, or requires updating. Notifications are sent to the primary method of contact (fax or email), as designed by the provider and included in the provider's CAQH record.

New CAQH Providers

If a provider is being credentialed with a health plan for the first time and does not have an existing record in the UPD for any of the health plans that use the CAQH database, a notification by a health plan to CAQH will trigger mailing of a welcome packet. The welcome packet is mailed to the address supplied to CAQH by the health plan (that is collected from the provider or designee) and will contain the provider's CAQH ID number and instructions on how to login to CAQH.

The following materials are included in the welcome packet (see end of this Appendix for samples):

- CAQH Cover Letter
- CAQH Credentialing

Faxing Supplemental Documentation

Please fax required supporting documents that supplement the credentialing application to CAQH with the provider-specific CAQH fax cover sheet. It is important to use the fax cover sheet specific to the individual provider that contains the provider's CAQH ID number and bar code. This information is uploaded into the CAQH provider record when the accompanying fax cover sheet is completed and submitted. No information is printed or reproduced on paper.

Cover Sheet Information

Individualized cover sheets can be found:

- online by clicking on the "Attachments" tab in the UPD
- by contacting the CAQH Help Desk at 1-888-599-1771

Individual cover sheets contain the following:

- provider-specific CAQH ID number
- provider-specific bar code
- description and coding of attachments

It is important to submit required credentialing documents to CAQH as these documents are necessary for the credentialing process. The required documents for health plan initial credentialing and recredentialing events are listed below.

Initial Credentialing Required Documents

- Consent and Release Form
- Malpractice Face Sheet
 - Helpful Hint:** Malpractice face sheets must include a provider's name, coverage amounts and to and from dates of coverage.
- Curriculum Vitae¹ must include five years of work history in month/year format and explanation of gaps of six months or greater.

CAQH Notification of Missing or Illegible Documents:

If faxed information is missing or rejected, the provider will receive a CAQH notification titled "CAQH Supporting Documents Missing" or "Provider Fax Submission Illegible or Incomplete".

¹ The application may be deemed complete in the CAQH system before this document is submitted and follow-up will occur during the primary source verification process.

Appendix 3 - CAQH UPD – application process

A CAQH notification titled “CAQH Confirmation: Application Complete” will be sent to the provider or credentialing administrator when the application data and required attachments are complete in the UPD. A description of application statuses in CAQH is located on the next page. This may be useful information for providers who contact the CAQH help desk for assistance. Note: A provider’s status will appear in the activity log of the provider’s record in CAQH.

CAQH Status:	Description:
New Provider	Provider has been entered into system by a plan and has not been sent a registration kit.
Initial Outreach	Provider has been sent outreach but has not yet registered with UPD or called help desk.
Alternate Outreach	Provider has been messaged at a secondary location after attempts are made to primary office location.
First Provider Contact	Provider has called or logged into UPD.
Application Data Submitted	Provider has progressed through UPD and “attested” or faxed in paper app. Still waiting for supporting docs.
Application Problem	Problem letter outstanding. (e.g., paper application doesn’t pass audit conditions)
Initial Application Complete	Information has been attested to and supporting documents received.
Reattestation	Information in system has been attested to.
Expired Attestation	Attestation expires if greater than 120 days old.
Undeliverable	Unable to outreach to provider due to lack of valid information.
Returned Mail	Registration kit mailing is returned from U.S. Postal Service due to poor mailing address, or provider no longer at the address.
Deceased/Retired	CAQH Help Desk is notified that provider is deceased or has retired from practice.
Opt Out	Provider has asked to be removed from the CAQH database.
Non-responder	Provider has this indicator marked after numerous attempts have been made when the provider's status is “Initial” or “Alternate Outreach”, “First Provider Contact”, “Application Data Submitted”, “Expired Attestation” or “Application Problem”.

Attestation

The CAQH system will prompt the provider to re-attest to the accuracy and completeness of the data every 120 days via email or fax using the primary method of contact information the provider includes in his or her CAQH

Appendix 3 - CAQH UPD – application process

record. If a provider's record has not been attested to after a period of time, the status changes to 'expired' and the data cannot be used for primary source verification.

Listed below are system notifications generated by CAQH on the re-attestation process.

- 15 day Reattestation Notice
- 10 day Reattestation Notice
- 5 day Reattestation Notice
- CAQH Reattestation Successful Notice
- CAQH Data Expiration Notice
- CAQH Expired Attestation

When Re-attesting to data on CAQH, please be sure to review the provider's supporting documents by clicking on the *Attachments* tab at the top of the page. Scroll down and review the provider's *Supporting Documents Received* that are on file. Click on the link for each document to ensure that all materials are current and nothing has expired. If a renewable document has expired, you will need to update this information. Below is a list of the most common documents that have effective dates and may expire. This is a partial list and does not represent a full list of documents that may expire.

- License
- DEA
- Malpractice Insurance
- Board Certifications

If data is up-to-date in the CAQH system and the provider has authorized all contracted health plans to access the credentialing data he/she will not receive a recredentialing notification. Over 68% of provider applications are up-to-date in CAQH and move directly to the primary source verification phase when their applications are due for review.

If a provider does not respond to CAQH notices to update the application, the provider is considered a non-responder by the CAQH system and will receive a notification to complete the CAQH application process as described earlier in this manual. This notification is printed on HCAS letterhead. A sample notification can be located in Appendix E.

The Universal Provider DataSource (UPD) Support

General UPD questions

Phone: 1-888-599-1771

Fax: 1-866-293-0414

Email: caqh.updhelp@acsgs.com

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«MailCode»
«FirstName» «MiddleInitial» «LastName» «Suffix»
«Address» **CAQH Provider ID:** «ProviderID»
«Address2»
«City», «State» «Zip»-«ExtZip»

Dear «FirstName» «LastName»,

At the request of one of the healthcare organizations with which you are contracted, or are in the process of contracting, please find enclosed the necessary information you will need to begin using the Universal Provider DataSource[®]. This secure, online service has been provided to you by many of the nation's leading health plans and other organizations to help streamline your credentialing paperwork. A current listing of participating organizations can be found at http://www.caqh.org/ucd_health_participating.php.

How the Universal Provider DataSource Works:

1. Participating health plans and other organizations submit a request to CAQH to include you in this national initiative.
2. To register, log on to www.caqh.org/cred using the CAQH Provider ID found at the top of this letter. Click on "Logging in for the first time," which is located on the right side of the screen.
3. You submit one standard application to a single database that meets the credentialing data needs of the dozens of participating organizations. You can submit your information online or via a toll-free fax number.
4. With your permission, participating organizations access your information and review according to their respective policies and procedures.
5. You can update your information at any time and release your updated information to participating organizations.

Note: You can only transmit your data to organizations with which you are already contracted or are in the process of contracting. Using the Universal Provider DataSource does not grant participation or constitute applying for participation with any organization. If you would like to participate with any other organizations, you must first contact the organization(s) directly to request a participation contract. Each participating organization continues to review and verify data, and makes an independent decision as to whether or not you meet its standards for participation.

A step-by-step checklist that walks you through the entire process, along with important background information, is also enclosed for your reference. Even if it is not time for you to be recredentialed, by completing the CAQH Universal Provider DataSource application now, you will only need to update to confirm your information remains accurate when the time comes.

To learn more about CAQH and the Universal Provider DataSource initiative, visit the CAQH Website at www.CAQH.org, where you can view an online demonstration of the application process. A current listing of participating organizations can be found at http://www.caqh.org/ucd_health_participating.php.

Alternatively, you may call the CAQH Help Desk at 888-599-1771 which is available Monday through Thursday from 7:00 a.m. to 9:00 p.m. (ET) and Friday from 7:00 a.m. to 7:00 p.m. (ET) to provide assistance with any questions you may have.

Sincerely,

CAQH

Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with any organization. If you would like to participate with any of these organizations, you must first contact the organization(s) directly to request a participating contract.

Appendix 3 - CAQH UPD – application process

CAQH Credentialing Checklist

What you will need

To make this process even easier, we've developed the following checklist of items you'll need to complete the application. Please gather the following information (if applicable) before you sit down and begin the online application:

- θ Your CAQH Provider ID number (located on this kit's cover letter)
- θ A previously completed credentialing application
- θ A list of all previous practice locations
- θ A copy of your curriculum vitae
- θ A copy of your medical license
- θ A copy of your DEA certificate
- θ A copy of your CDS certificate
- θ A copy of your IRS Form W-9
- θ Various identification numbers (UPIN, Medicare, Medicaid, etc.)
- θ A copy of your malpractice insurance face sheet and summary of any pending and settled cases

Getting Started

If you are entering credentialing information for an individual provider:

- θ Open Internet browser
- θ In the address box located at the top of your browser window, type: www.caqh.org/cred
- θ Select the "Logging in for the first time?" link
- θ Enter the provider's CAQH Provider ID number (located at the top right of the cover letter)
- θ Enter one of the identifiers requested
- θ Complete the online application

If you are entering credentialing information for multiple providers in your practice:

The CAQH Practice Manager Module—a feature of Universal Provider DataSource—will make your data entry task much easier. By creating a "template" with information that is common across providers in your group, you can "import" this generic record into an individual provider's application.

Once you are ready to begin entering information:

- θ Open Internet browser
- θ In the address box located at the top of your browser window, type the following address:
<https://upd.caqh.org/pmm>
- θ Register by establishing your username and password as directed

Questions?

If you have questions about the application process, please contact the CAQH Help Desk at **888-599-1771** or by sending an email to caqh.updhelp@acsgs.com.



Appendix 4 - NCQA – Credentialing Standards

The National Committee for Quality Assurance (NCQA) accredits many health plans in Wisconsin. NCQA has the following standards for a provider credentialing program:

Credentialing Policies (CR 1)

- Does the organization have clearly defined and documented procedures for assessing its practitioners' qualifications and practice history?
- Does the organization identify which types of practitioners must be credentialed?
- Does the organization have policies and procedures that define practitioner rights to review and correct credentialing information?

Credentialing Committee (CR 2)

- Has the organization designated a committee to make recommendations regarding decisions about practitioners' credentials?

Initial Credentialing Verification (CR 3)

- Prior to allowing network participation, does the organization verify practitioners' credentials, including a valid license to practice medicine; education and training, malpractice history; and work history within the timeframes specified within NCQA standards and guidelines?

Application and Attestation (CR 4)

- Do practitioners applications to the organization include a current and signed attestation about why they cannot perform certain tasks; a history of loss of medical license and felony convictions; a history of limitation of privileges or disciplinary actions; and current malpractice insurance coverage?

Initial Sanction Information (CR 5)

- Before making a decision on a practitioner's qualifications, does the organization receive and review information from third parties, such as information about any disciplinary actions?

Practitioner Office Site Quality (CR 6)

- Does the plan verify through an onsite visit, after reaching a member complaint-threshold, the quality of all practitioners' offices?
- Does the plan take necessary steps when an office does not meet its standards, and does it evaluate those steps regularly until the office improves?

Recredentialing Verification (CR 7)

- Does the organization reevaluate practitioners' qualifications every 36 months?
- Before reevaluating its decision on a practitioner's qualifications, does the organization receive information from third parties, such as information about disciplinary actions?

Recredentialing Cycle Length (CR 8)

- Does the organization reevaluate practitioners' qualifications every 36 months?

Ongoing Monitoring (CR 9)

- Between recredentialing cycles, does the organization conduct ongoing monitoring of practitioner sanctions, complaints and quality issues?
- Does the organization take appropriate action when issues are identified?

Notification to Authorities and Practitioner Appeal Rights (CR 10)

- Does the organization have a process for discontinuing the contracts of practitioners who demonstrate poor performance?
- Is there a process in place by which the practitioner can appeal the organization's decision?

Appendix 4 - NCQA – Credentialing Standards

- Does the organization report to appropriate authorities when it suspends or terminates practitioners?

Assessment of Organizational Providers (CR 11)

- Does the organization confirm that hospitals, home health care agencies, skilled nursing facilities, nursing homes and behavioral health facilities are in good standing with state and federal agencies and accrediting organizations?
- Does the organization re-review these standings at least every three years?

Delegation of Credentialing (CR 12)

- If the organization delegates to a third party decisions on evaluating or reevaluating a provider's qualifications, is the decision-making process—including the responsibilities of the organization and delegated party—clearly documented?
- Does the organization evaluate and approve the delegated party's plan on a regular basis?



Appendix 5 – Wisconsin HEDIS – Provider Scores 2013

NCQA (National Committee for Quality Assurance) evaluates health plan activities that ensure each doctor is licensed and trained to practice medicine and that the health plan's members are happy with their doctors. *For example:* Does the health plan check whether physicians have had sanctions or lawsuits against them? How do health plan members rate their personal doctors or nurses? To evaluate these activities, NCQA uses records of doctors' credentials, interviews health plan staff, and grades the results from consumer surveys.

Name	Line of Business	Product	Qualified Providers	Overall Accreditation Status
Aetna Life Insurance Company (Wisconsin)	Commercial	PPO	commendable	accredited
Cigna Health and Life Insurance Company - Wisconsin	Commercial	PPO	excellent	accredited
CompCare Health Services Insurance Corporation dba Anthem BCBS in Wisconsin	Commercial	HMO/POS Combined	excellent	commendable
Connecticut General Life Insurance Company - Wisconsin	Commercial	PPO	excellent	accredited
Dean Health Plan, Inc.	Commercial	HMO	excellent	excellent
Group Health Cooperative of South Central Wisconsin	Commercial	HMO	excellent	excellent
Gundersen Lutheran Health Plan, Inc.	Commercial	HMO	excellent	commendable
HealthPartners, Inc.	Commercial	HMO/POS/PPO	excellent	excellent
HMO Illinois and Blue Advantage HMO	Commercial	HMO	excellent	commendable
Humana Insurance Company (Wisconsin)	Commercial	PPO	excellent	accredited
Humana Wisconsin Health Organization Insurance Corporation	Commercial	HMO/POS	commendable	commendable
Medica	Commercial	HMO/POS/PPO	commendable	commendable
Medical Associates Clinic Health Plan of Wisconsin dba Medical Associates Health Plans	Commercial	HMO/POS	excellent	excellent
MercyCare HMO, Inc d/b/a/ MercyCare Health Plans	Commercial	HMO	excellent	excellent
Network Health Plan	Commercial	HMO	commendable	excellent
Physicians Plus Insurance Corporation	Commercial	HMO/POS	excellent	excellent
Security Health Plan of Wisconsin, Inc	Commercial	HMO/POS	excellent	excellent
United Healthcare Services, Inc (Wisconsin)	Commercial	PPO	excellent	commendable
UnitedHealthcare Insurance Company (Wisconsin)	Commercial	PPO	excellent	commendable
UnitedHealthcare of Wisconsin, Inc.	Commercial	HMO/POS	excellent	excellent
Unity Health Plans Insurance Corporation	Commercial	HMO/POS	excellent	excellent
WPS Health Plan, Inc.	Commercial	HMO/POS	excellent	commendable

Rating Key

Excellent - Service and clinical quality that **meet or exceed rigorous requirements** for consumer protection and quality improvement. HEDIS results are in the highest range of national performance.

Commendable - Service and clinical quality that **meet rigorous requirements** for consumer protection and quality improvement.

Accredited - Service and clinical quality that **meet basic requirements** for consumer protection and quality improvement. Organizations awarded this status **must take further action to achieve a higher accreditation status.**

Provisional - Service and clinical quality that **meet basic requirements** for consumer protection and quality improvement. Organizations awarded this status **must take significant action to achieve a higher accreditation status.**



Appendix 6 – URAC Credentialing Standards

Utilization Review Accreditation Commission (URAC) has the following standards for provider credentialing by its accredited member health plans.¹

CR 1 – Practitioner and Facility Credentialing

For most organizations, MD's and DO's. Organizations can choose whether or not to credential non-physician professionals. The organization's provider directory will be considered as the list of providers that are within the credentialing scope.

CR 2 – Credentialing Program Oversight

The organization's senior clinical staff person is responsible for oversight of clinical aspects of the credentialing program.

CR 3 – Credentialing Committee

There is a credentialing committee that:

- Has as a member at least one participating provider who is a practitioner and with no other role in organization management
- Discusses if providers meet reasonable standards of care
- Utilize clinical peer input when discussing standards of care for a specific type of provider
- Has final authority to:
 - Approve or disapprove applications
 - Delegate the authority to approve clean applications to the senior clinical staff person, provided that such designation is documented and provides reasonable guidelines
- Keeps minutes of all committee meetings including documenting all actions
- Gives guidance on the overall direction of the credentialing program to organization staff
- Evaluates the effectiveness of the credentialing program and reports such to organization management
- Reviews and approves credentialing policies and procedures
- Meets as often as necessary to fulfill its responsibilities, but no less than quarterly

CR 4 – Credentialing Program Plan

The organization has a written description for its credentialing program that:

- Has been approved by the credentialing committee
- Defines the scope and objectives of the credentialing program and the roles and responsibilities of the credentialing committee, the medical director (or clinical director), and the credentialing staff
- Defines criteria for qualification as a participating provider
- Defines the information collected during the credentialing process and how the information is verified for each type of provider credentialed
- Includes rules about maintaining and storing credentialing information and files
- Includes a statement that the organization will not discriminate against any provider
- Is reviewed and updated at least annually by the credentialing committee

CR 5 – Credentialing Application

Each applicant within the scope of the credentialing program submits an application that includes at least the following:

- Education and professional training, including board certification status
- State licensure information, including current license(s) and history of licensure in all jurisdictions
- Evidence of current DEA certificate or state controlled dangerous substance certificate, if applicable
- Proof of liability insurance and professional liability claims history
- History of sanctions, loss or limitation of privileges or disciplinary activity
- Hospital affiliations or privileges, if applicable
- Physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the practitioner's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients

¹ PROVIDER CREDENTIALING ACCREDITATION, VERSION 6.0 from www.namss.org/Portals/0/.../URAC_Summary.doc

Appendix 6 – URAC Credentialing Standards

- Signed and dated attestation statement regarding the completeness and accuracy of the application
- Signed and dated statement authorizing the organization to collect information necessary to verify the information in the application.

CR 6 – Credentialing Confidentiality

The organization ensures the confidentiality of credentialing information and limits access to credentialing files to authorized persons only.

CR 7 – Review of Credentialing Information

The organization has mechanisms to review credentialing information for completeness, accuracy, and any conflicting information.

CR 8 – Credentialing Communication Mechanism

There is a mechanism to communicate with providers about their credentialing status when requested and, prior to review, accept additional information from providers to correct incomplete, inaccurate, or conflicting credentialing information.

CR 9 – Primary Source Verification

The organization performs primary source verification of state licensure and board certification or highest level of education.

CR 10 – Consumer Safety Credentialing Investigation

There is a mechanism to conduct additional review and investigation of credentialing applications where the credentialing process reveals factors that may impact the quality of care or services.

CR 11 – Credentialing Application Review

There is a mechanism to provide for review and approval of the credentialing application prior to the applicant's designation as a participating provider.

The only exception to this standard is when a provider is granted provisional participation status by the senior clinical staff person. This status must be time-limited and granted due to continuity or quality of care issues. The full credentialing process must be completed as quickly as possible.

CR 12 – Credentialing Timeframe

No credentialing application is submitted for initial review if it is signed and dated more than 180 days prior to credentialing committee review or if it contains primary or secondary source verification information collected more than six months prior to review.

CR 13 – Credentialing Determination Notification

The organization provides written notification to providers within 10 calendar days of the determination.

CR 14 – Participating Providers Credentials Monitoring

There is a process to monitor continuing compliance with criteria for network participation and mechanisms to respond in cases where a participating provider ceases to comply with criteria. The organization is expected to routinely monitor reports of disciplinary actions published by state licensing boards and the U.S. Department of Health and Human Services, Office of Inspector (OIG) or periodically query the National Practitioner Data Bank (NPDB).

CR 15 - Recredentialing

Providers within the scope of the credentialing program are recredentialled at least every three years. The recredentialing cycle is calculated from month/day/year to month/day/year. For example, a provider initially credentialled on 3/13/2007, must be recredentialled no later than 3/13/2010.

CR 16 – Recredentialing & Participating Provider Quality Monitoring

The recredentialing process:

- requires an application updating any information subject to change
- verifies through primary or secondary sources information that is subject to change
- considers information regarding the participating provider's performance within the organization, including information collected through the quality management program.

CR 17 – Credentialing Delegation

The organization complies with the Core Standards for any credentialing functions it delegates to another entity. The organization retains authority to make the final credentialing determinations and conducts on-site surveys of each entity that performs credentialing functions on behalf of the organization at least every three years.

CR 18 – Credentialing Phase-In

The organization's credentialing program is implemented within the following time frames:

Appendix 6 – URAC Credentialing Standards

- at the time of the on-site review, the credentialing process has been completed for at least 100 practitioners
- at least 50% of participating providers (practitioners and facilities) have been credentialed within 2 years from the date of initial URAC accreditation
- 100% of all participating providers within the credentialing scope are credentialed within 3 years from the date of initial URAC accreditation.



Appendix 7 –Revalidation Letter for Medicare - Sample



Medicare

**NOTE: MEDICARE PART B TRANSFERRED TO NGS SO LATER LETTERS
WILL COME FROM THEM AND NOT WPS.**

PROVIDER REVALIDATION REQUEST—IMMEDIATE ACTION REQUIRED

Month Day, Year

PROVIDER/SUPPLIER NAME

ADDRESS 2

ADDRESS 1

CITY STATE ZIP CODE

NPI:

Control Number:

Medicare PTAN(s):

Dear

THIS IS A REVALIDATION REQUEST IMMEDIATELY REVIEW, UPDATE AND CERTIFY YOUR
INFORMATION VIA THE INTERNET-BASED PECOS SYSTEM OR SUBMIT AN UPDATED PROVIDER
ENROLLMENT PAPER APPLICATION 855 FORM

In accordance with the Patient Protection and Affordable Care Act, Section 6401 (a), all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers & suppliers to revalidate enrollment information every five years (reference 42 CFR § 424.515). To ensure compliance with these requirements, existing regulations at 42 CFR § 424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information using one of the following methods:

Providers and suppliers can revalidate their provider enrollment in the Medicare program using either the:

(1) Internet-based Provider Enrollment, Chain, and Ownership System (PECOS)

To revalidate via the Internet-based PECOS, go to <https://pecos.cms.hhs.gov>. This system allows you to review information currently on file. Remember to print, sign, date, and mail the certification statement along with all required supporting documentation. To process the revalidation, the original signature and documentation must be received in our office within 15 days of the application Internet submission date. (The mailing addresses for our offices are on page 2 of this letter.)

You must have an active National Provider Identifier (NPI) and have a web user account (User ID/Password) established in the National Plan and Provider Enumeration System



Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare Contractor
P.O. Box 1787 • Madison, WI 53701 • Phone 608-221-4711

Appendix 7 –Revalidation Letter for Medicare - Sample

practitioners will access Internet-based PECOS with the same User ID and password that they use for NPPES. For provider/supplier organizations who would like an individual(s) (Authorized Official) to use Internet-based PECOS on behalf of a provider or supplier organization, the Authorized Official must register with the PECOS Identification and Authentication system. If you have not registered, do so now by going to <https://pecos.cms.hhs.gov>. This registration process can take up to three (3) weeks. If additional time is required to complete the revalidation applications, you may request one 60-day extension, which will begin on the date of the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to Wisconsin Physicians Service at the address in “2” below. The request should include justification of why a 60-day extension is needed. The request may also be made by calling our office. To avoid any registration issues, review the Internet-based PECOS related documents available on the CMS Web site (<https://www.cms.gov/MedicareProviderSupEnroll>). If you are having issues with your User

ID/Password and are unable to log into Internet-based PECOS, please contact the External User Services (EUS) Help Desk at 1-866-484-8049 / TTY: 1-866-523-4759.

(2) Paper Application Form

To revalidate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at <https://www.cms.gov/MedicareProviderSupEnroll/>. Mail your completed application and all required supporting documentation to Wisconsin Physicians Service at the address below, based on the state in which you are located.

Wisconsin, Illinois, Michigan, Indiana, Iowa, Kansas, Missouri, and Nebraska:

Wisconsin Physicians Service
Medicare Provider Enrollment
Post Office Box 8248
Madison, WI 53708-8248

Priority Mailing Address
Wisconsin Physicians Service
Medicare Provider Enrollment
1707 W. Broadway
Madison, WI 53713-1834

Minnesota:

Wisconsin Physicians Service
Medicare Provider Enrollment
8120 Penn Avenue South
Bloomington, MN 55431-1394

If additional time is required to complete the revalidation applications, you may request one 60-day extension, which will begin on the date of the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to Wisconsin Physicians Service. The request should include justification of why a 60-day extension is needed. The request may

Appendix 7 –Revalidation Letter for Medicare - Sample

also be made by calling our office.

With the exception of physicians, non-physician practitioners, physician group practices and non-group practices, all other revalidating providers and suppliers who submit enrollment applications using the CMS-855A, CMS-855B (not including physician/non-physician practitioner organizations) or the CMS-855S or associated Internet-based PECOS enrollment application must submit with their application, confirmation that the application fee was paid or a request for a hardship exception. (Note: Physicians who are DMEPOS suppliers are subject to the fee for the DMEPOS enrollment.) Application fees must be submitted via PECOS <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>, which will allow payment of the fee by electronic check, debit, or credit card prior to submitting the application (reference 42 CFR 424.514).

If you feel you qualify for a hardship exception waiver, submit a letter on practice letterhead and financial statements requesting a waiver in lieu of the enrollment fee along with your application or certification statement. Revalidations are processed only when application fees have cleared or the hardship waiver has been granted. You will be notified by mail if your waiver request has been granted or if a fee is required. More information on who is subject to an enrollment fee can be found at:

<https://www.cms.gov/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf>.

For more information on the application fees and other screening requirements under the Patient Protection and Affordable Care Act (PPACA), view the MLN Matters Article at:

<http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf>.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to Medicare within 30 days. All other changes must be reported within 90 days. For most, but not all, other providers and suppliers, changes of ownership or control, including changes in authorized official(s), must be reported with 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated. We strongly recommend that you mail your documents using a method that allows for proof of receipt.

In submitting your revalidation application, please note:

- For non-physician practitioners, required supporting documentation includes copies of their license, diploma and/or academic transcript, certification, and any other documents needed to establish that they meet Medicare's eligibility requirements for their specialty.

Do not use the CMS-855O form to submit your revalidation application. This form is used only by physicians and practitioners who enroll in Medicare for the sole purpose of being the ordering/referring provider on Medicare claims. The revalidation requirement does not apply to these providers.

- Indicate that you are revalidating your Medicare enrollment as the reason for submitting the application.

Appendix 7 –Revalidation Letter for Medicare - Sample

- Physicians and nonphysician practitioners who reassign their Medicare benefits to a group practice or organization must submit both a CMS-855I and CMS-855R to revalidate their Medicare enrollment.
- Enclose this letter or a copy of it with your revalidation application or certification statement.
- A CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement is required only if the provider is not already receiving Medicare payment via electronic funds transfer or if changes are being made to their existing EFT arrangements.
- A CMS-460 Medicare Participating Physician or Supplier Agreement should not be submitted; the revalidation process does not affect the current participation status of providers.
- If you have received this letter for a PTAN(s) associated with a practice(s) at which you are no longer active, please submit the appropriate CMS-855 as a change of information to notify us of the termination.
- All Medicare PTANs referenced in this letter must be revalidated (or terminated). If you have received this letter for multiple PTANs associated with different legal business entities/tax identification numbers, submit separate CMS-855 forms for the PTANs associated with each entity.

If you have any questions regarding this letter, please call our toll-free telephone numbers between the hours of 8:00 A.M. and 4:00 P.M. (C.T.) Monday through Friday. Our toll-free telephone numbers are based on the state in which providers are located:

Wisconsin and Illinois: 877-908-8476 **Iowa, Kansas, Missouri, and Nebraska:** 866-503-7664
Minnesota: 866-564-0315 **Michigan and Indiana:** 855-280-5484

You may also visit our Web site at <http://www.wpsmedicare.com/> for additional information regarding the enrollment process or the CMS-855 enrollment forms.

Sincerely,

Wisconsin Physicians Service
Medicare Provider Enrollment Department



Expediting Medicare Provider Revalidations Using PECOS

Appendix 7 –Revalidation Letter for Medicare - Sample

Wisconsin Physicians Service (WPS) knows how valuable a Medicare provider's time is. Because Medicare revalidation is a legislative reality and something providers will do at least every five years, WPS wants to help providers expedite the revalidation process by offering these helpful hints in addition to the attached revalidation request:

- Use the Internet-based Provider Enrollment, Change, and Ownership System (PECOS) at <https://pecos.cms.hhs.gov> for your revalidation because: Our experience shows that PECOS revalidations (and new applications) process faster The system ensures applications are complete and then automatically routes them to the Correct contractor without mailing delays It allows you to review, update, and certify information currently on file
- Establish a web user account at [https://nppes/cms/hms.gov/NPPES/Welcome.do](https://nppes.cms/hms.gov/NPPES/Welcome.do) because you will use the same user id/password to access PECOS National note you must use Provider Identifier (NPI) to use PECOS
- Ensure you complete all sections because any missing information means a delay in handling until you supply the required information. Common areas missed include: Section 4C which requires disclosure of all locations, including A single location for sole practitioners/owners individual Effective date
 Mail all required supporting paper documentation because any missing information means a delay in handling until you supply the required information. Common documents not supplied for both physicians and non-physician specialties include: Driver's License Medical or other license Federal IRS documents
 Transcripts
- Send the attached revalidation request letter, your supporting documents, and your certification statement within 15 days of completing the PECOS revalidation
- Submit confirmation with your documents that you paid your application fee, if applicable. To pay your fee, you must use PECOS (<https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>). The PECOS payment module allows you to pay by electronic check, debit, or credit card prior to submitting the application
- Respond quickly to this request. You have only 60 days from the post mark date of the revalidation request to complete the revalidation process. If you don't respond in 60 days (or request an extension), we are required to deactivate your Medicare billing privileges

WPS Medicare Revalidation Helpful Hints - SAMPLE



Paper Medicare Provider Revalidations

Appendix 7 –Revalidation Letter for Medicare - Sample

If you choose to use paper applications for your revalidation, WPS offers these helpful hints to ensure timely handling of your revalidation in addition to the attached revalidation request:

- Download the appropriate and current CMS-855 Medicare Enrollment application from <https://www.cms.gov/MedicareProviderSupEnroll/>.
- Ensure you complete all sections because any missing information means a delay in handling until you supply the required information. Common areas missed include: **all Section 4**, but espec
4C which requires disclosure of all locations, including Effective date
A single location for sole practitioners/owners individual Medical or c
 Mail all required supporting paper documentation, including the attached revalidation request letter, because any missing information means a delay in handling until you supply the required information. Common documents not supplied for both physicians and non-physician specialties include:
Driver's License or Passport Driver transcripts Medical or c
documents
 Submit your confirmation that you paid your application fee with your documents, if applicable. To pay your fee, you must use PECOS (<https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>). The PECOS payment module allows you to pay by electronic check, debit, or credit card prior to submitting the application. You will need to establish a web user account at <https://nppes/cms/hms/gov/NPPES/Welcome.do> to access PECOS because you use the same user id/password to access PECOS
- Respond quickly to this request. You have only 60 days from the post mark date of revalidation request to complete the revalidation process. If you don't respond in 60 days (or request an extension), we are required to deactivate your Medicare billing privileges

WPS Medicare Revalidation Helpful Hints - SAMPLE

Original at http://www.wpsmedicare.com/part_b/departments/enrollment/_files/sample-revalidation-ltr.pdf



Appendix 8 - Medical Curriculum Vitae – Content Information

Most of the information you will need to complete an agreement with a health plan is included on a physician's curriculum vitae.

Personal Information

Name (legal), degree

Contact Information

Business Address

Business Phone Number

Fax Number

Email

Foreign Languages (native, fluent, proficient, or working knowledge)

Education

All undergraduate and graduate education.

Post Graduate Education and Training

Internships

Residencies

Post-doctoral fellowships

Certifications (If applicable)

All board and/or specialty certifications with years received

Medical Licensures (If applicable)

All medical and/or other state/federal licensures with year issued and status (*active* or *inactive*)

Military Service (If applicable)

Rank, location of service and dates

Employment History

Academic Appointments

Other Employment

Separate faculty appointments from other administrative, hospital or industry appointments and program affiliations

Professional Society Memberships

Years and type of membership for each professional

Clinical Activities (If applicable)

Include years where applicable

Describe clinical expertise (include description of any specific clinical techniques)

Describe scope of clinical practice:

Site of primary practice and size (Hospital, VA, affiliated hospital, etc.)

Total number of patients/procedures conducted in a given time period

Number of referrals received

Responsibilities with practice (leadership/administrative roles)

Total time spent in clinical duties

Describe innovative techniques that have changed or influenced practice

Describe any modifications to clinical enterprise

Describe development of any clinical programs

Administrative Service

Institutional Service

Years, committees serviced or chaired (department committees, SOM committees, hospital committees, VA committees, special assignments, etc.)

Include a subsection for each institution if there are multiple activities at several institutions

Appendix 8 - Medical Curriculum Vitae – Content Information

Local and National Service

Years of service and name of organization

Teaching Service

List chronologically all current and past teaching responsibilities, keeping basic sciences separate from clinical sciences.

Separate student teaching from resident teaching

Grant Support

Active Grants

List grants chronologically by start date in separate sections for active, submitted or completed.

Pending Grants

Include only grants that have actually been submitted, including date the grant was submitted

Completed Grants

All extramural and intramural grants

Patents, Inventions and Copyrights (If applicable)

List all patents, inventions and/or copyrights issued.

Publications

Peer-reviewed journal articles

Non-peer-reviewed journal articles

Web based journal articles

Books

Book Chapters

Abstracts and/or Proceedings



SAMPLE TEMPLATE

Agency
Organization Name/Title
City, State, and Zip Code

Memorandum of Understanding
between
The Agency and Service Provider

SUBJECT: Format and Use of a Memorandum of Understanding

1. Purpose. This paragraph defines, in as few words as possible, the purpose of the memorandum of understanding and outlines the terms of the contract.
2. Reference. This paragraph will list the references that are directly related to the MOU.
3. Problem. Present a clear, concise statement of the problem, to include a brief background.
4. Scope. Add a succinct statement specifying the area of the MOU.
5. Understandings, agreements, support and resource needs. List the understandings, agreements, support and resource needs, and responsibilities of and between each of the parties or agencies involved in the MOU.
6. Specify a certain contracting period. (Example: The ending date of an MOU cannot exceed the end of the current fiscal year).
7. Specify monetary and performance terms. Explain payment rates with all rates agreed to by both parties. Designate specific time frames and dollar amounts to be paid upon completion of each identifiable task.
8. Include a monitoring component to determine contract compliance. If the terms of the MOU are not being fulfilled, allow for a termination clause.
9. Effective date. Enter the date the agreement will become effective.

SIGNATURE BLOCK
XXXXXXXX, XXXX
XXXXXXXX, XXXXXX

(Date)

SIGNATURE BLOCK
XXXXXXXX, XXXX
XXXXXXXX, XXXXXX

(Date)



Appendix 10 – Agreement Format

Typical Payer Standard Contract¹

A. PREAMBLE

1. Parties Agreement is by and between (Payer or Plan) and LHD

B. DEFINITIONS

1. Defined Terms: Any terms used specifically (i.e., capitalized) in contract should be defined.
2. Medical Necessity Definition: Use acceptable community standard, not Plan standard.

C. PLAN RESPONSIBILITIES

1. Financial Incentives: Any incentive used to encourage members to use LHD (e.g. waiver of or use of smaller coinsurance).
2. If the Plan is not the Payer: Will provide LHD with information on relevant third parties (e.g. claims administrator) within 30 days.
3. Payer or Plan will not market LHD to other PPOs, HMOs, or other insurance companies without LHD's prior written consent. [NOTE: this is called a "silent PPO".]
4. Medical Records: Plan to secure patient authorization for release of records. Negotiate the current standard copying fee, if possible.
5. Provider Directories: Copies to be provided to LHD within thirty (30) days of each revision/publication, if plan does not use website.
6. Plan Network: Specify Plan's current provider network for relevant geographic area.
7. Utilization Review: Determinations to be based on medical necessity, not the Plan's unilateral determination. Appeals procedure should be specific.
8. Plan Names: Specify name(s) and brief description(s).

D. PROVIDER RESPONSIBILITIES

1. Hold-Harmless: All contracts as required by law².
2. Manuals: Resist specifications that are per "current Provider Manual". If required, need thirty (30) days' notice of any material changes to manual. Date of current manual should be specified in contract and reviewed prior to signing.
3. Medical Records: Access for one year following agreement termination or date of service, whichever is sooner.
4. Services: Define services covered by Agreement, or note exclusions ("carve outs"). This is absolute for capitation agreements.

E. BILLING

5. Claims Submission: >>XXX<< days to submit claim.
6. Claims Payment: Payment to be made within thirty (30) days from receipt of claim, including re-pricing or in accordance with Prompt Pay Law³. EOB to specify applicable contract adjustments. [NOTE: Negotiate to have payment revert to 100%, if not received within specified time].
7. Claims Denial: Appeal procedure must be specified. Operational denial: Negotiate for "penalty" fee rather than total denial.

¹ <http://www.aameda.org/MemberServices/Exec/Articles/spg04/BrooksArticle.pdf>

² WI 609.24 (3) HOLD HARMLESS REQUIREMENTS

³ WI 628.46: All claim types must be paid in 30 days or subject to 12% annual interest.

Appendix 10 – Agreement Format

8. Over/under Payments: Provider has the right to re-bill if underpaid. Provider will agree to like language regarding overpayments. Limited time frame of one year for re-billing, if mutually agreed.
9. COB: How is Coordination of Benefits applied to claims?

F. TERM/TERMINATION

1. Termination: 30 days - with cause (included *time to cure* (fix the problem)), 180 days - without cause, immediately for bankruptcy, insolvency, loss of licensure.
2. Term/Renewal: Specify effective day and annual renewal date. Indicate whether dates apply to admissions or discharges on or after XX/XX/20XX. New rates to be agreed upon within 60 days after renewal date or either party may terminate immediately.

G. MARKETING

1. Provider Listings: Plan will list LHD as provider. LHD may/will list Plan in listing of plans in which it participates. No other use of LHD name without LHD's prior written consent. Marketing Plan will promote LHD to the same extent it promotes other participating hospitals.

H. MISCELLANEOUS

1. Indemnification: Each party agrees to indemnify, defend and hold harmless the other, its agents and employees from and against any and all liability or expense.
2. Insurance: Negotiate to maintain general and professional liability coverage at the current amounts approved by the Plan. [Minimum should be defined to be in compliance with WI law - WI Statute § 655.23]
3. Dispute Resolution: Mediation or binding arbitration in accordance with the American Arbitration Association in the jurisdiction of the LHD's domicile.
4. Governing Law: Wisconsin or not specified.
5. Assignment: None without prior written authorization.
6. Notices: LHD Health Officer or other title as preferred.
7. Addresses/Phones: Required for claims submission and utilization review (where applicable).
8. Any other local, state or federal laws that may be applicable at the time should be defined.

I. REIMBURSEMENT

1. Reimbursement Terms: Specify appropriate CPT, HCPCS, ICD-9s, etc.
2. Plan Specifics: If Plan uses its commercial code edit application, specify updates will be provided 30 days prior to their effective date. Provider and Plan will renegotiate terms if effect of re-weighting is greater than three (3) percent.
3. Fee Base Schedule: All elements of the schedule need to be defined – how the fee is arrived at, what is the default if a code isn't listed on the schedule or is new.

J. SIGNATURES

1. Provider: Health Officer, County/City Representative (as required)
2. Plan: President/CEO and/or VP Fiscal Services or Contracting/Compliance



Appendix 11 –Certificate of Coverage - Sample

This is a sample page of the Certificate of Insurance, or face sheet, required by most payers to meet liability or medical malpractice requirements. This copy represents Burnett County.

CERTIFICATE OF INSURANCE

ISSUE DATE:

AEGIS CORPORATION
 18550 W. CAPITOL DRIVE
 BROOKFIELD, WISCONSIN 53045
 TEL: (800)236-6885
 FAX: (262)781-7743

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED:

COMPANIES AFFORDING COVERAGE

COMPANY:
WISCONSIN COUNTY MUTUAL INSURANCE CORPORATION
LETTER A

COVERAGES
 THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OF OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES, LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

CO. LTR	TYPE OF INSURANCE	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	LIMITS
A	LIABILITY GENERAL LIABILITY LAW ENFORCEMENT LIABILITY PUBLIC OFFICIALS E&O AUTOMOBILE LIABILITY ALL OWNED AUTOS HIRED & NON-OWNED AUTOS UNINSURED MOTORISTS				EACH OCCURRENCE \$10,000,000

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS:

CERTIFICATE HOLDER:

AUTHORIZED REPRESENTATIVE

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.



Appendix 12 – Commercial Timely Filing Limits

Name	Commercial Timely Filing Limit
Anthem WI	Claims must be submitted within the timely filing time frame specified in your contract
Care Wisconsin Health Plan, Inc.	
Children's Community Health Plan, Inc	No longer than 180 days from the date of service
Community Care Health Plan, Inc.	
Compcare Health Services Insurance Corporation	
Dean Health Plan, Inc.	No longer than 180 days from the date of service
Group Health Cooperative of Eau Claire	COB claims: Provider must submit the documents within 90 days from the date on the primary RA.
Group Health Cooperative of South Central Wisconsin	
Gundersen Health Plan, Inc. (formerly Gundersen Lutheran Health Plan)	A claim for benefits should be submitted within 60 days of the date services. COB claims: no later than six (6) months from the date of receipt of the primary carrier Explanation of Benefits (EOB)/Payment
Health Tradition Health Plan	BadgerCare: Health Tradition is limiting the timely filing period to 6 months.
HealthPartners Insurance Company	Medicaid: Must be received within 180 days from the date of service
Humana Wisconsin Health Organization Insurance Corporation	
Independent Care Health Plan	Submit all claims for services rendered where iCare Medicare is primary or iCare Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.
Managed Health Services Insurance Corp.	Received by MHS within 60 days of the date of service or as defined in your MHS contract. Out-of-plan providers must be received by MHS within 365 days of the date of service
Medical Associates Clinic Health Plan of Wisconsin,	
Medicaid	365 days from DOS COB claims:365 days from date of other payer EOB
Medicare	As a result of the PPACA, claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare.
MercyCare HMO, Inc. (page 94 of provider manual, section 16.7)	Claims must be filed on a valid claim form within 180 days (6 months) from the date of services
Molina Healthcare of Wisconsin, Inc. (acquired Abri Health Plan effective September 1, 2010)	New claims: 60 days from DOS, "unless otherwise indicated in contract" COB claims: 60 days from the date on the remit from the primary payer, "unless otherwise indicated in contract"
Network Health Plan	Must receive all paper and electronic claims, including late charges, within 90 days of the date of service
Partnership Health Plan, Inc	
Physicians Plus Insurance Corporation	Set up on provider contract
Security Health Plan of Wisconsin, Inc.	Dates of services older than 180 days will be denied
Trilogy Health Insurance, Inc.	
TriCare (formerly CHAMPUS)	One year from the date of service
UnitedHealthcare of Wisconsin, Inc.	
Unity Health Plans Insurance Corporation	Within the timely filing limit required in the provider contract
WEA Insurance Corporation	
WPS Health Plan, Inc. (acquired Arise Health Plan - formerly Prevea Health Plan)	requires password to access individual plan data



Appendix 13 – COB Determination Rules – Example

This appendix gives you an idea of how complex COB (Coordination of Benefits) rules can be. It is the actual language from the UnitedHealthcare Essential Benefits Policy assigned to Wisconsin, by CMS, for use in the Health Exchange.

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract

Appendix 13 – COB Determination Rules – Example

may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Appendix 13 – COB Determination Rules – Example

- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - 1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - 2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - 1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care

Appendix 13 – COB Determination Rules – Example

- coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
- 2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - 3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - 4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
 - c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
 4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
 5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
 6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

Appendix 13 – COB Determination Rules – Example

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Source: http://www.oci.wi.gov/healthcare_ref/ehb_certificate.pdf



Appendix 14 – Procedure Codes for Immunizations

Manual	Section	Procedure Code	CPT description	Short Description
CPT	Immunoglobulin Products	90281	Immune globulin (IG), human, for intramuscular use	IG
CPT	Immunoglobulin Products	90283	Immune globulin (IGIV), human, for intravenous use	IGIV
CPT	Immunoglobulin Products	90287	Botulinum antitoxin, equine, any route	botulinum antitoxin
CPT	Immunoglobulin Products	90288	Botulinum immune globulin, human, for intravenous use	
CPT	Immunoglobulin Products	90291	Cytomegalovirus immune globulin (CMV-IGIV), human, for intravenous use	CMVIG
CPT	Immunoglobulin Products	90296	Diphtheria antitoxin, equine, any route	diphtheria antitoxin
CPT	Immunoglobulin Products	90371	Hepatitis B immune globulin (HBIG), human, for intramuscular use	HBIG
CPT	Immunoglobulin Products	90375	Rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous use	RIG
CPT	Immunoglobulin Products	90376	Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use	RIG
CPT	Immunoglobulin Products	90378	Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each	RSV-MAb
CPT	Immunoglobulin Products	90384	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	
CPT	Immunoglobulin Products	90385	Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use	
CPT	Immunoglobulin Products	90386	Rho(D) immune globulin (RhIgIV), human, for intravenous use	
CPT	Immunoglobulin Products	90389	Tetanus immune globulin (TIG), human, for intramuscular use	TIG
CPT	Immunoglobulin Products	90393	Vaccinia immune globulin, human, for intramuscular use	vaccinia immune globulin
CPT	Immunoglobulin Products	90396	Varicella-zoster immune globulin, human, for intramuscular use	VZIG
CPT	Immunoglobulin Products	90399	Unlisted immune globulin	
CPT	Injections Provided w/ Counseling	90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	

Appendix 14 – Procedure Codes for Immunizations

CPT	Injections Provided w/ Counseling	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 (List separately in addition to code for primary procedure)	
CPT	Injections & Other routes of administration w/o physician counseling	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	
CPT	Injections & Other routes of administration w/o physician counseling	90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	
CPT	Injections & Other routes of administration w/o physician counseling	90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	
CPT	Injections & Other routes of administration w/o physician counseling	90474	Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	
CPT	Vaccination Products	90476	Adenovirus vaccine, type 4, live, for oral use	adenovirus, type 4
CPT	Vaccination Products	90477	Adenovirus vaccine, type 7, live, for oral use	adenovirus, type 7
CPT	Vaccination Products	90581	Anthrax vaccine, for subcutaneous use	anthrax
CPT	Vaccination Products	90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use	BCG
CPT	Vaccination Products	90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	
CPT	Vaccination Products	90632	Hepatitis A vaccine, adult dosage, for intramuscular use	Hep A, adult
CPT	Vaccination Products	90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use	Hep A, ped/adol, 2 dose
CPT	Vaccination Products	90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use	Hep A, ped/adol, 3 dose
CPT	Vaccination Products	90636	Hepatitis A and hepatitis B (HepA-HepB), adult dosage, for intramuscular use	Hep A-Hep B

Appendix 14 – Procedure Codes for Immunizations

CPT	Vaccination Products	90644	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months, for intramuscular use	Meningococcal C/Y-HIB PRP
CPT	Vaccination Products	90645	Haemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use	Hib (HbOC)
CPT	Vaccination Products	90646	Haemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use	Hib (PRP-D)
CPT	Vaccination Products	90647	Haemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use	Hib (PRP-OMP)
CPT	Vaccination Products	90648	Haemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use	Hib (PRP-T)
CPT	Vaccination Products	90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent) 3 dose schedule, for intramuscular use	HPV, quadrivalent
CPT	Vaccination Products	90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use	HPV, bivalent
CPT	Vaccination Products	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use	influenza, seasonal, intradermal, preservative free
CPT	Vaccination Products	90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use	Influenza, seasonal, injectable, preservative free
CPT	Vaccination Products	90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years of age and above, for intramuscular use	Influenza, seasonal, injectable, preservative free
CPT	Vaccination Products	90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use	Influenza, seasonal, injectable
CPT	Vaccination Products	90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use	Influenza, seasonal, injectable
CPT	Vaccination Products	90660	Influenza virus vaccine, live, for intranasal use	influenza, live, intranasal
CPT	Vaccination Products	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use	

Appendix 14 – Procedure Codes for Immunizations

CPT	Vaccination Products	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	Influenza, high dose seasonal
CPT	Vaccination Products	90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use	
CPT	Vaccination Products	90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	
CPT	Vaccination Products	90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	
CPT	Vaccination Products	90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	
CPT	Vaccination Products	90669	Pneumococcal conjugate vaccine, 7 valent, for intramuscular use	pneumococcal conjugate PCV 7
CPT	Vaccination Products	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Pneumococcal conjugate PCV 13
CPT	Vaccination Products	90672	Influenza virus vaccine, quadrivalent, live, for intranasal use	influenza, live, intranasal, quadrivalent
CPT	Vaccination Products	90675	Rabies vaccine, for intramuscular use	rabies, intramuscular injection
CPT	Vaccination Products	90676	Rabies vaccine, for intradermal use	rabies, intradermal injection
CPT	Vaccination Products	90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	rotavirus, pentavalent
CPT	Vaccination Products	90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	rotavirus, monovalent
CPT	Vaccination Products	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	influenza, live, injectable, quadrivalent, preservative free

Appendix 14 – Procedure Codes for Immunizations

CPT	Vaccination Products	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use	influenza, live, injectable, quadrivalent, preservative free
CPT	Vaccination Products	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use	
CPT	Vaccination Products	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use	
CPT	Vaccination Products	90690	Typhoid vaccine, live, oral	typhoid, oral
CPT	Vaccination Products	90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	typhoid, ViCPs
CPT	Vaccination Products	90692	Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use	typhoid, parenteral
CPT	Vaccination Products	90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (U.S. military)	typhoid, parenteral, AKD (U.S. military)
CPT	Vaccination Products	90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use	DTaP-IPV
CPT	Vaccination Products	90698	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use	DTaP-Hib-IPV
CPT	Vaccination Products	90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for use in individuals younger than seven years, for intramuscular use	DTaP
CPT	Vaccination Products	90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for use in individuals younger than seven years, for intramuscular use	DTaP, 5 pertussis antigens
CPT	Vaccination Products	90702	Diphtheria and tetanus toxoids (DT) adsorbed for use in individuals younger than seven years, for intramuscular use	DT (pediatric)
CPT	Vaccination Products	90703	Tetanus toxoid adsorbed, for intramuscular use	tetanus toxoid, adsorbed

Appendix 14 – Procedure Codes for Immunizations

CPT	Vaccination Products	90704	Mumps virus vaccine, live, for subcutaneous use	mumps
CPT	Vaccination Products	90705	Measles virus vaccine, live, for subcutaneous use	measles
CPT	Vaccination Products	90706	Rubella virus vaccine, live, for subcutaneous use	rubella
CPT	Vaccination Products	90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	MMR
CPT	Vaccination Products	90708	Measles and rubella virus vaccine, live, for subcutaneous use	M/R
CPT	Vaccination Products	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	MMRV
CPT	Vaccination Products	90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use	OPV
CPT	Vaccination Products	90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use	IPV
CPT	Vaccination Products	90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use	Td (adult) preservative free
CPT	Vaccination Products	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use	Tdap
CPT	Vaccination Products	90716	Varicella virus vaccine, live, for subcutaneous use	varicella
CPT	Vaccination Products	90717	Yellow fever vaccine, live, for subcutaneous use	yellow fever
CPT	Vaccination Products	90719	Diphtheria toxoid, for intramuscular use	Td (adult), adsorbed
CPT	Vaccination Products	90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use	DTP-Hib
CPT	Vaccination Products	90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use	DTaP-Hib
CPT	Vaccination Products	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use	DTaP-Hep B-IPV
CPT	Vaccination Products	90725	Cholera vaccine for injectable use	cholera
CPT	Vaccination Products	90727	Plague vaccine, for intramuscular use	plague
CPT	Vaccination Products	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use	pneumococcal polysaccharide PPV23

Appendix 14 – Procedure Codes for Immunizations

CPT	Vaccination Products	90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use	meningococcal MPSV4
CPT	Vaccination Products	90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use	Meningococcal MCV4O
CPT	Vaccination Products	90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use	meningococcal MCV4P
CPT	Vaccination Products	90735	Japanese encephalitis virus vaccine, for subcutaneous use	Japanese encephalitis SC
CPT	Vaccination Products	90736	Zoster (shingles) vaccine, live, for subcutaneous injection	zoster
CPT	Vaccination Products	90738	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	Japanese Encephalitis IM
CPT	Vaccination Products	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	
CPT	Vaccination Products	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	Hep B, dialysis
CPT	Vaccination Products	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	Hep B, adult
CPT	Vaccination Products	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use	Hep B, adolescent or pediatric
CPT	Vaccination Products	90746	Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use	Hep B, adult
CPT	Vaccination Products	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	Hep B, dialysis
CPT	Vaccination Products	90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	Hib-Hep B
CPT	Vaccination Products	90749	Unlisted vaccine/toxoid	
HCPCS	Immunization Administration	G0008	Administration of influenza virus vaccine	
HCPCS	Immunization Administration	G0009	Administration of pneumococcal vaccine	
HCPCS	Immunization Administration	G0010	Administration of hepatitis B vaccine	



Appendix 15 – CPT Corrections Errata Sample



Corrections Document—CPT® (Current Procedural Terminology) 2013¹

Introduction

► *Current Procedural Terminology* (CPT®), Fourth Edition, is a set of...
Inclusion of a descriptor and its associated five-digit code number in ... ◀

Add new text symbols ►◀ to denote revision of the text in the Introduction to the CPT code set.

Evaluation and Management (E/M) Services Guidelines

Counseling

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- *Diagnostic results, impressions, and/or recommended diagnostic studies*
- *Prognosis*
- *Risks and benefits of management (treatment) options*
- *Instructions for management (treatment) and/or follow-up*
- *Importance of compliance with chosen management (treatment) options*
- *Risk factor reduction*
- *Patient and family education*

► (For psychotherapy, see 90832-90834, 90836-90840) ◀

Add an instructional parenthetical note following the counseling guidelines to coincide with the new psychotherapy range of codes 90832-90834 and 90836-90840

Evaluation and Management Tables

Initial Neonatal Intensive Care

Initial Neonatal Intensive Care	
Code	99477
Age	28 days of age or younger
Weight	1600-5000 gms+
Presenting Problem	Requires Intensive Observation, Frequent Interventions/Other Intensive Care Services

Remove reference to weight “1500-5000 gms” from the (E/M) Initial Neonatal Intensive Care table

Sign up to receive e-mail notification when changes are posted to the AMA Web site for CPT Announcements, Category II codes, Category III codes, Vaccine codes, Errata and Panel Agenda Proposals and Subsequent Actions. You may also receive notice when registration opens for the CPT Editorial Panel meeting.

Sign up for list serve to be notified of any future changes to the CPT errata accessed via the following link:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/announcements-reports/e-mail-notifications.page>

¹ <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/errata.page?>



Appendix 15 – CPT Corrections Errata Sample

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Appendix 16 - Modifiers

2013 CPT Modifiers

Modifier	Description
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional during a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
26	Professional Component
32	Mandated Services
33	Preventive Service
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4kg
66	Surgical Team
76	Repeat Procedure by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by Same Physician or Other Qualified Health Care Professional for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
99	Multiple Modifiers

Appendix 16 - Modifiers

2013 HCPCS Modifiers

Code	SHORT DESCRIPTION
A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	Dressing for 9 or more wound
AA	Anesthesia perf by anesgst
AD	MD supervision, >4 anes proc
AE	Registered dietician
AF	Specialty physician
AG	Primary physician
AH	Clinical psychologist
AI	Principal physician of rec
AJ	Clinical social worker
AK	Non participating physician
AM	Physician, team member svc
AP	No dtmn of refractive state
AQ	Physician service HPSA area
AR	Physician scarcity area
AS	Assistant at surgery service
AT	Acute treatment
AU	Uro, ostomy or trach item
AV	Item w prosthetic/orthotic
AW	Item w a surgical dressing
AX	Item w dialysis services
AY	Item/service not for ESRD tx
AZ	Physician serv in dent HPSA
BA	Item w pen services
BL	Spec acquisition blood prods
BO	Nutrition oral admin no tube
BP	Bene electd to purchase item
BR	Bene elected to rent item
BU	Bene undecided on purch/rent
CA	Procedure payable inpatient
CB	ESRD bene part a snf-sep pay
CC	Procedure code change
Code	SHORT DESCRIPTION
CD	AMCC test for ESRD or MCP MD

CE	Med neces AMCC tst sep reimb
CF	AMCC tst not composite rate
CG	Policy criteria applied
CH	0 percent impaired, ltd, res
CI	1 to <20 percent impaired
CJ	20 to <40 percent impaired
CK	40 to <60 percent impaired
CL	60 to <80 percent impaired
CM	80 to <100 percent impaired
CN	100 percent impaired, ltd
CR	Catastrophe/disaster related
CS	Gulf Oil 2010 Spill Related
E1	Upper left eyelid
E2	Lower left eyelid
E3	Upper right eyelid
E4	Lower right eyelid
EA	ESA, anemia, chemo-induced
EB	ESA, anemia, radio-induced
EC	ESA, anemia, non-chemo/radio
ED	HCT>39% or Hgb>13g>=3 cycle
EE	HCT>39% or Hgb>13g<3 cycle
EJ	Subsequent claim
EM	Emer reserve supply (ESRD)
EP	Medicaid EPSDT program svc
ET	Emergency Services
EY	No md order for item/service
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
FA	Left hand, thumb
FB	Item provided without cost
FC	Part credit, replaced device
FP	Svc part of family plan pgm
G1	URR reading of less than 60
G2	URR reading of 60 to 64.9
G3	URR reading of 65 to 69.9

Appendix 16 - Modifiers

G4	URR reading of 70 to 74.9
G5	URR reading of 75 or greater
G6	ESRD patient <6 dialysis/mth
G7	Payment limits do not apply
G8	Monitored anesthesia care
G9	MAC for at risk patient
GA	Liability waiver ind case
GB	Claim resubmitted
GC	Resident/teaching phys serv
GD	Unit of service > MUE value
GE	Resident prim care exception
GF	Nonphysician serv c a hosp
GG	Payment screen mam + diagmam
GH	Diag mammo to screening mammo
GJ	Opt out provider of er srvc
GK	Actual item/service ordered
GL	Upgraded item, no charge
GM	Multiple transports
GN	OP speech language service
GO	OP occupational therapy serv
GP	OP PT services
GQ	Telehealth store and forward
GR	Service by va resident
GS	Epo/darbepoietin reduced 25%
GT	InteractiveTelecommunication
GU	Liability waiver rout notice
GV	Attending phys not hospice
GW	Service unrelated to term co
GX	Voluntary liability notice
GY	Statutorily excluded
GZ	Not reasonable and necessary
H9	Court-ordered
HA	Child/adolescent program
HB	Adult program non-geriatric
HC	Adult program geriatric
HD	Pregnant/parenting program
HE	Mental health program
HF	Substance abuse program
HG	Opioid addiction tx program
HH	Mental hlth/substance abs pr
HI	M hlth/m retrdtn/dev dis pro
HJ	Employee assistance program
HK	Spec hgh rsk mntl hlth pop p

HL	intern
HM	Less than bachelor degree lv
HN	Bachelors degree level
HO	Masters degree level
HP	Doctoral level
HQ	Group setting
HR	Family/couple w client prsnt
HS	Family/couple w/o client prs
HT	Multi-disciplinary team
HU	Child welfare agency funded
HV	Funded state addiction agncy
HW	State mntl hlth agncy funded
HX	County/local agency funded
HY	Funded by juvenile justice
HZ	Criminal justice agncy fund
J1	CAP no-pay for prescript num
J2	CAP restock of emerg drugs
J3	CAP drug unavail thru cap
J4	DMEPOS comp bid furn by hosp
JA	Administered intravenously
JB	Administered subcutaneously
JC	Skin substitute graft
JD	Skin sub not used as a graft
JW	Discarded drug not administe
K0	Lwr ext prost functnl lvl 0
K1	Lwr ext prost functnl lvl 1
K2	Lwr ext prost functnl lvl 2
K3	Lwr ext prost functnl lvl 3
K4	Lwr ext prost functnl lvl 4
KA	Wheelchair add-on option/acc
KB	>4 modifiers on claim
KC	Repl special pwr wc intrface
KD	Drug/biological DME infused
KE	Bid under round 1 DMEPOS CB
KF	FDA class III device
KG	DMEPOS comp bid prgm no 1
KH	DMEPOS ini clm, pur/1 mo rnt
KI	DMEPOS 2nd or 3rd mo rental
KJ	DMEPOS PEN pmp or 4-15mo rnt
KK	DMEPOS comp bid prgm no 2
KL	DMEPOS mailorder comp bid
KM	Rplc facial prosth new imp
KN	Rplc facial prosth old mod

Appendix 16 - Modifiers

KO	Single drug unit dose form
KP	First drug of multi drug u d
KQ	2nd/subsqnt drg multi drg ud
KR	Rental item partial month
KS	Glucose monitor supply
KT	Item from noncontract supply
KU	DMEPOS comp bid prgm no 3
KV	DMEPOS item, profession serv
KW	DMEPOS comp bid prgm no 4
KX	Documentation on file
KY	DMEPOS comp bid prgm no 5
KZ	New cov not implement by m+c
LC	Lft circum coronary artery
LD	Left ant des coronary artery
LL	Lease/rental (appld to pur)
LM	Left main coronary artery
LR	Laboratory round trip
LS	FDA-monitored IOL implant
LT	Left side
M2	Medicare secondary payer
MS	6-mo maint/svc fee parts/lbr
NB	Drug specific nebulizer
NR	New when rented
NU	New equipment
P1	Normal healthy patient
P2	Patient w/mild syst disease
P3	Patient w/severe sys disease
P4	Pt w/sev sys dis threat life
P5	Pt not expect surv w/o oper
P6	Brain-dead pt organs removed
PA	Surgery, wrong body part
PB	Surgery, wrong patient
PC	Wrong surgery on patient
PD	Inp admit w/in 3 days
PI	PET tumor init tx strat
PL	Progressive addition lenses
PS	PET tumor subseq tx strategy
PT	Clrctal screen to diagn
Q0	Invest clinical research
Q1	Routine clinical research
Q2	HCFA/ORD demo procedure/svc
Q3	Live donor surgery/services
Q4	Svc exempt - ordrg/rfrng MD

Q5	Subst MD svc, recip bill arr
Q6	Locum tenens MD service
Q7	One Class A finding
Q8	Two Class B findings
Q9	1 Class B & 2 Class C fndngs
QC	Single channel monitoring
QD	Rcrdg/strg in sld st memory
QE	Prescribed oxygen < 1 LPM
QF	Prscrbd oxygen >4 LPM & port
QG	Prescribed oxygen > 4 LPM
QH	Oxygen cnsvrg dvc w del sys
QJ	Patient in state/locl custod
QK	Med dir 2-4 cncrnt anes proc
QL	Patient died after amb call
QM	Ambulance arr by provider
QN	Ambulance furn by provider
QP	Individually ordered lab tst
QS	Monitored anesthesia care
QT	Rcrdg/strg tape analog recdr
QW	CLIA waived test
QX	CRNA svc w/ MD med direction
QY	Medically directed CRNA
QZ	CRNA svc w/o med dir by MD
RA	Replacement of DME item
RB	Replacement part, DME item
RC	Right coronary artery
RD	Drug admin not incident-to
RE	Furnish full compliance REMS
RI	Ramus intermedius cor artery
RR	Rental (DME)
RT	Right side
SA	Nurse practitioner w physici
SB	Nurse midwife
SC	Medically necessary serv/sup
SD	Serv by home infusion RN
SE	State/fed funded program/ser
SF	2nd opinion ordered by PRO
SG	ASC facility service
SH	2nd concurrent infusion ther
SJ	3rd concurrent infusion ther
SK	High risk population
SL	State supplied vaccine
SM	Second opinion

Appendix 16 - Modifiers

SN	Third opinion
SQ	Item ordered by home health
SS	HIT in infusion suite
ST	Related to trauma or injury
SU	Performed in phys office
SV	Drugs delivered not used
SW	Serv by cert diab educator
SY	Contact w/high-risk pop
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TA	Left foot, great toe
TC	Technical component
TD	RN
TE	LPN/LVN
TF	Intermediate level of care
TG	Complex/High Tech level care
TH	OB TX/Srvcs prenatal/postpart
TJ	Child/adolescent program gp
TK	Extra patient or passenger
TL	Early intervention IFSP
TM	Individualized ed prgm(IEP)
TN	Rural/out of service area
TP	Med transprt unloaded vehicl
TQ	BLS by volunteer amb providr
TR	School-based IEP out of dist
TS	Follow-up service

TT	Additional patient
TU	Overtime payment rate
TV	Holiday/weekend payment rate
TW	Back-up equipment
U1	M/caid care lev 1 state def
U2	M/caid care lev 2 state def
U3	M/caid care lev 3 state def
U4	M/caid care lev 4 state def
U5	M/caid care lev 5 state def
U6	M/caid care lev 6 state def
U7	M/caid care lev 7 state def
U8	M/caid care lev 8 state def
U9	M/caid care lev 9 state def
UA	M/caid care lev 10 state def
UB	M/caid care lev 11 state def
UC	M/caid care lev 12 state def
UD	M/caid care lev 13 state def
UE	Used durable med equipment
UF	Services provided, morning
UG	Services provided, afternoon
UH	Services provided, evening
UJ	Services provided, night
UK	Svc on behalf client-collat
UN	Two patients served
UP	Three patients served
UQ	Four patients served
UR	Five patients served
US	Six or more patients served
V5	Vascular catheter
V6	Arteriovenous graft
V7	Arteriovenous fistula
VP	Aphakic patient



Appendix 17 – Place of Service – Codes

2013 Place of Service – Codes

1	Pharmacy	41	Ambulance - Land
2	Unassigned	42	Ambulance – Air or Water
3	School	43-48	Unassigned
4	Homeless Shelter	49	Independent Clinic
5	Indian Health Service	50	Federally Qualified Health Center
6	Indian Health Service - Provider-based Facility	51	Inpatient Psychiatric Facility
7	Tribal 638 - Free standing facility	52	Psychiatric Facility-Partial Hospitalization
8	Tribal 638 - Provider based facility	53	Community Mental Health Center
9	Prison/Correctional Facility	54	Intermediate Care Facility/Mentally Retarded
10	Unassigned	55	Residential Substance Abuse Treatment Facility
11	Office	56	Psychiatric Residential Treatment Center
12	Home	57	Non-residential Substance Abuse Treatment Facility
13	Assisted Living Facility	58-59	Unassigned
15	Mobile Unit	60	Mass Immunization Center
16	Temporary Lodging	61	Comprehensive Inpatient Rehabilitation Facility
17	Walk-in Retail Health Clinic	62	Comprehensive Outpatient Rehabilitation Facility
18	Place of Employment-Worksite	63-64	Unassigned
19	Unassigned	65	End-Stage Renal Disease Treatment Facility
20	Urgent Care Facility	66-70	Unassigned
21	Inpatient Hospital	71	Public Health Clinic
22	Outpatient Hospital	72	Rural Health Clinic
23	Emergency Room – Hospital	73-80	Unassigned
24	Ambulatory Surgical Center	81	Independent Laboratory
25	Birthing Center	82-98	Unassigned
26	Military Treatment Facility	99	Other Place of Service
27-30	Unassigned		
31	Skilled Nursing Facility		
32	Nursing Facility		
33	Nursing Facility		
34	Hospice		
35-40	Unassigned		



Appendix 18 - Immunization Coding – 2013

2013 Codes

Immunization Administration:

90460, 90461, 90471, 90472,
90473, 90474, G0008, G0009,
G0010

Vaccines:

Hepatitis A:

Havrix®, *VAQTA*®, *Twinrix*®
90632, 90633, 90634, 90636

Hemophilus influenza b:

HibTITER® *PedvaxHIB*®, *ActHIB*®
90645, 90646, 90647, 90648

HPV:

90649 (*Gardasil*®)
90650 (*Cervarix*®)

Influenza virus ('flu'):

Afluria® *Fluarix*® *Fluvirin*® *Fluzone*®
High-Dose Fluzone® *FluLaval*®
FluMist®

90654, 90655, 90656, 90657,
90658, 90660, 90661, 90662,
90664, 90666, 90667, 90668,
90672, Q2034, Q2035, Q2036,
Q2037, Q2038, Q2039

Pneumococcal conjugate:

Prevnar® *Prevnar13*®
90669, 90670, S0195

Rotavirus: *ROTATEQ*® *Rotarix*®

90680, 90681

Dtap / Dtpap-IPV, Dtap-Hib-IPV / DTP / DT / Tetanus / Polio / Tdap/ Measles, Mumps, Rubella / MMR:

90696, 90698, 90700, 90702,
90703, 90704, 90705, 90706,
90707, 90708, 90710, 90713,
90714, 90715, 90719, 90720,
90721, 90723

Varicella ('chicken pox') Varivax®:

90716
Pneumococcal: *PNEUMOVAX*®
90732

Meningococcal:

Menomune® *Menactra*®
90733, 90734

Zoster/Shingles: *Zostavax*®

90736
Hepatitis B:
RECOMBIVAXHB® *Engerix-B*®
90740, 90743, 90744, 90746,
90747, 90748

Main Dx Codes

V01.0 Contact with or exposure to cholera
V01.1 Contact with or exposure to tuberculosis
V01.2 Contact with or exposure to poliomyelitis
V01.3 Contact with or exposure to smallpox
V01.4 Contact with or exposure to rubella
V01.5 Contact with or exposure to rabies
V01.6 Contact with or exposure to venereal diseases
V01.71 Contact with or exposure to varicella
V01.79 Contact with or exposure to other viral diseases
V01.81 Contact with or exposure to anthrax
V01.82 Exposure to SARS-associated coronavirus
V01.83 Contact with or exposure to escherichia coli (E. coli)
V01.84 Contact with or exposure to meningococcus
V01.89 Contact with or exposure to other communicable diseases
V01.9 Contact with or exposure to unspecified communicable disease

V02.0 Carrier or suspected carrier of cholera
V02.1 Carrier or suspected carrier of typhoid
V02.2 Carrier or suspected carrier of amebiasis
V02.3 Carrier or suspected carrier of other gastrointestinal pathogens
V02.4 Carrier or suspected carrier of diphtheria
V02.51 Carrier or suspected carrier of group B streptococcus
V02.52 Carrier or suspected carrier of other streptococcus
V02.53 Carrier or suspected carrier of Methicillin susceptible *Staphylococcus aureus*
V02.54 Carrier or suspected carrier of Methicillin resistant *Staphylococcus aureus*
V02.59 Carrier or suspected carrier of other specified bacterial diseases
V02.60 Viral hepatitis carrier, unspecified
V02.61 Hepatitis B carrier
V02.62 Hepatitis C carrier

Appendix 18 - Immunization Coding – 2013

V02.69	Other viral hepatitis carrier	V04.81	Need for prophylactic vaccination and inoculation against influenza
V02.7	Carrier or suspected carrier of gonorrhea	V04.82	Need for prophylactic vaccination and inoculation against respiratory syncytial virus (RSV)
V02.8	Carrier or suspected carrier of other venereal diseases	V04.89	Need for prophylactic vaccination and inoculation against other viral diseases
V02.9	Carrier or suspected carrier of other specified infectious organism	V05.0	Need for prophylactic vaccination and inoculation against arthropod-borne viral encephalitis
V03.0	Need for prophylactic vaccination and inoculation against cholera alone	V05.1	Need for prophylactic vaccination and inoculation against other arthropod-borne viral diseases
V03.1	Need for prophylactic vaccination and inoculation against typhoid-paratyphoid alone [TAB]	V05.2	Need for prophylactic vaccination and inoculation against leishmaniasis
V03.2	Need for prophylactic vaccination and inoculation against tuberculosis [BCG]	V05.3	Need for prophylactic vaccination and inoculation against viral hepatitis
V03.3	Need for prophylactic vaccination and inoculation against plague	V05.4	Need for prophylactic vaccination and inoculation against varicella
V03.4	Need for prophylactic vaccination and inoculation against tularemia	V05.8	Need for prophylactic vaccination and inoculation against other specified disease
V03.5	Need for prophylactic vaccination and inoculation against diphtheria alone	V05.9	Need for prophylactic vaccination and inoculation against unspecified single disease
V03.6	Need for prophylactic vaccination and inoculation against pertussis alone	V06.0	Need for prophylactic vaccination and inoculation against cholera with typhoid-paratyphoid [cholera + TAB]
V03.7	Need for prophylactic vaccination and inoculation against tetanus toxoid alone	V06.1	Need for prophylactic vaccination and inoculation against diphtheria-tetanus-pertussis, combined [DTP] [DTaP]
V03.81	Other specified vaccinations against hemophilus influenza, type B [Hib]	V06.2	Need for prophylactic vaccination and inoculation against diptheria-tetanus-pertussis with typhoid-paratyphoid (DTP + TAB)
V03.82	Other specified vaccinations against streptococcus pneumoniae [pneumococcus]	V06.3	Need for prophylactic vaccination and inoculation against diptheria-tetanus-pertussis with poliomyelitis [DTP + polio]
V03.89	Other specified vaccination	V06.4	Need for prophylactic vaccination and inoculation against measles-mumps-rubella (MMR)
V03.9	Need for prophylactic vaccination and inoculation against unspecified single bacterial disease	V06.5	Need for prophylactic vaccination and inoculation against tetanus-diphtheria [Td] (DT)
V04.0	Need for prophylactic vaccination and inoculation against poliomyelitis	V06.6	Need for prophylactic vaccination and inoculation against streptococcus pneumoniae [pneumococcus] and influenza
V04.1	Need for prophylactic vaccination and inoculation against smallpox	V06.8	Need for prophylactic vaccination and inoculation against other combinations of diseases
V04.2	Need for prophylactic vaccination and inoculation against measles alone	V06.9	Unspecified combined vaccine
V04.3	Need for prophylactic vaccination and inoculation against rubella alone		
V04.4	Need for prophylactic vaccination and inoculation against yellow fever		
V04.5	Need for prophylactic vaccination and inoculation against rabies		
V04.6	Need for prophylactic vaccination and inoculation against mumps alone		
V04.7	Need for prophylactic vaccination and inoculation against common cold		

Appendix 18 - Immunization Coding – 2013

V14.7	Personal history of allergy to serum or vaccine	V64.05	Vaccination not carried out because of caregiver refusal
V64.00	Vaccination not carried out, unspecified reason	V64.06	Vaccination not carried out because of patient refusal
V64.01	Vaccination not carried out because of acute illness	V64.07	Vaccination not carried out for religious reasons
V64.02	Vaccination not carried out because of chronic illness or condition	V64.08	Vaccination not carried out because patient had disease being vaccinated against
V64.03	Vaccination not carried out because of immune compromised state	V64.09	Vaccination not carried out for other reason
V64.04	Vaccination not carried out because of allergy to vaccine or component		

October 1, 2014 ICD-10 codes

Z20.	Contact with and (suspected) exposure to communicable diseases
Z20.0	Contact with and (suspected) exposure to intestinal infectious diseases
Z20.01	Contact with and (suspected) exposure to intestinal infectious diseases due to Escherichia coli (E. coli)
Z20.09	Contact with and (suspected) exposure to other intestinal infectious diseases
Z20.1	Contact with and (suspected) exposure to tuberculosis
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Z20.3	Contact with and (suspected) exposure to rabies
Z20.4	Contact with and (suspected) exposure to rubella
Z20.5	Contact with and (suspected) exposure to viral hepatitis
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
Z20.7	Contact with and (suspected) exposure to pediculosis, acariasis and other infestations
Z20.8	Contact with and (suspected) exposure to other communicable diseases
Z20.81	Contact with and (suspected) exposure to other bacterial communicable diseases
Z20.810	Contact with and (suspected) exposure to anthrax
Z20.811	Contact with and (suspected) exposure to meningococcus
Z20.818	Contact with and (suspected) exposure to other bacterial communicable diseases
Z20.82	Contact with and (suspected) exposure to other viral communicable diseases
Z20.820	Contact with and (suspected) exposure to varicella
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
Z20.89	Contact with and (suspected) exposure to other communicable diseases
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
Z21.	Asymptomatic human immunodeficiency virus [HIV] infection status
Z22.	Carrier of infectious disease
Z22.0	Carrier of typhoid
Z22.1	Carrier of other intestinal infectious diseases
Z22.2	Carrier of diphtheria
Z22.3	Carrier of other specified bacterial diseases
Z22.31	Carrier of bacterial disease due to meningococci
Z22.32	Carrier of bacterial disease due to staphylococci

Appendix 18 - Immunization Coding – 2013

- Z22.321 Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus
- Z22.322 Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus
- Z22.33 Carrier of bacterial disease due to streptococci
- Z22.330 Carrier of Group B streptococcus
- Z22.338 Carrier of other streptococcus
- Z22.39 Carrier of other specified bacterial diseases
- Z22.4 Carrier of infections with a predominantly sexual mode of transmission
- Z22.5 Carrier of viral hepatitis
- Z22.50 Carrier of unspecified viral hepatitis
- Z22.51 Carrier of viral hepatitis B
- Z22.52 Carrier of viral hepatitis C
- Z22.59 Carrier of other viral hepatitis
- Z22.6 Carrier of human T-lymphotropic virus type-1 [HTLV-1] infection
- Z22.8 Carrier of other infectious diseases
- Z22.9 Carrier of infectious disease, unspecified

Z23. Encounter for immunization

- Z28. Immunization not carried out and underimmunization status
- Z28.0 Immunization not carried out because of contraindication
- Z28.01 Immunization not carried out because of acute illness of patient
- Z28.02 Immunization not carried out because of chronic illness or condition of patient
- Z28.03 Immunization not carried out because of immune compromised state of patient
- Z28.04 Immunization not carried out because of patient allergy to vaccine or component
- Z28.09 Immunization not carried out because of other contraindication
- Z28.1 Immunization not carried out because of patient decision for reasons of belief or group pressure
- Z28.2 Immunization not carried out because of patient decision for other and unspecified reason
- Z28.20 Immunization not carried out because of patient decision for unspecified reason
- Z28.21 Immunization not carried out because of patient refusal
- Z28.29 Immunization not carried out because of patient decision for other reason
- Z28.3 Underimmunization status
- Z28.8 Immunization not carried out for other reason
- Z28.81 Immunization not carried out due to patient having had the disease
- Z28.82 Immunization not carried out because of caregiver refusal
- Z28.89 Immunization not carried out for other reason
- Z28.9 Immunization not carried out for unspecified reason
- Z88.7 Allergy status to serum and vaccine status



Appendix 19 – Superbill – Sample

Family Practice Management Superbill Template

From the American Academy of Family Practice (AAFP) Family Practice Management Toolkit
<http://www.aafp.org/fpmv/20080900/43inse.html>

Date of service:		Waiver? <input type="checkbox"/>	
Patient name:		Insurance:	
Address:		Subscriber name:	
Phone:		Group #:	Previous balance:
DOB:		Copay:	Today's charges:
Age:	Sex:	Account #:	Today's payment: check#
		Physician name:	Balance due:

NAME	Office visit	New	Est	NAME	Office procedures	NAME	Laboratory	
	Minimal		99211		Anoscopy	46600	Venipuncture	36415
	Problem focused	99201	99212		Audiometry	92551	Blood glucose, monitoring device	82962
	Expanded problem focused	99202	99213		Cerumen removal	69210	Blood glucose, visual dipstick	82948
	Detailed	99203	99214		Colposcopy	57452	CBC, w/ auto differential	85025
	Comprehensive	99204	99215		Colposcopy w/ biopsy	57455	CBC, w/ auto differential	85027
	Comprehensive (new patient)	99205			ECG, w/ interpretation	93000	Cholesterol	82465
	Significant, separate service	-25	-25		ECG, rhythm strip	93040	Hemocult, qualac	82270
	Well visit	New	Est		Endometrial biopsy	58100	Hemocult, immunoassay	82274
	< 1 y	99391	99391		Flexible sigmoidoscopy	45330	Hemoglobin A1C	85018
	1-4 y	99392	99392		Flexible sigmoidoscopy w/ biopsy	45331	Lipid panel	80061
	5-11 y	99393	99393		Fracture care, cast/splint	29.....	Liver panel	80076
	12-17 y	99394	99394		Site: _____		KOH prep (skin, hair, nails)	87220
	18-39 y	99395	99395		Nebulizer	94640	Metabolic panel, basic	80048
	40-64 y	99396	99396		Nebulizer demo	94664	Metabolic panel, comprehensive	80053
	65 y +	99397	99397		Spirometry	94010	Mononucleosis	86308
	Medicare preventive services				Spirometry, pre and post	94060	Pregnancy, blood	84703
	Fap		Q0091		Tympanometry	92567	Pregnancy, urine	81025
	Pelvic & breast		G0101		Vasectomy	55250	Renal panel	80069
	Prostate/PSA		G0103		Skin procedures	Units	Sedimentation rate	85651
	Tobacco counseling/3-10 min		99406		Burn care, initial	16000	Strep, rapid	86403
	Tobacco counseling/>10 min		99407		Foreign body, skin, simple	10120	Strep culture	87081
	Welcome to Medicare exam		G0344		Foreign body, skin, complex	10121	Strep A	87880
	ECG w/Welcome to Medicare exam		G0366		I&D, abscess	10060	TB	86580
	Flexible sigmoidoscopy		G0104		I&D, hematoma/seroma	10140	UA, complete, non-automated	81000
	Hemocult, qualac		G0107		Laceration repair, simple	120.....	UA, w/ micro, non-automated	81002
	Flu shot		G0008		Site: _____ Size: _____		UA, w/ micro, non-automated	81003
	Pneumonia shot		G0009		Laceration repair, layered	120.....	Urine colony count	87086
	Consultation/preop clearance				Site: _____ Size: _____		Urine culture, presumptive	87088
	Expanded problem focused		99242		Lesion, biopsy, one	11100	Wet mount/KOH	87210
	Detailed		99243		Lesion, biopsy, each add'l	11101	Vaccines	
	Comprehensive/mod complexity		99244		Lesion, destruct., benign, 1-14	17110	DT, <7 y	90702
	Comprehensive/high complexity		99245		Lesion, destruct., premal, single	17000	DTP	90701
	Other services				Lesion, destruct., premal, ea. add'l	17003	DtaP, <7 y	90700
	After posted hours		99050		Lesion, excision, benign	114.....	Flu, 6-35 months	90657
	Evening/weekend appointment		99051		Site: _____ Size: _____		Flu, 3 y +	90658
	Home health certification		G0180		Lesion, excision, malignant	116.....	Hep A, adult	90632
	Home health recertification		G0179		Site: _____ Size: _____		Hep A, ped/adol, 2 dose	90633
	Post-op follow-up		99024		Lesion, paring/cutting, one	11055	Hep B, adult	90746
	Prolonged/30-74 min		99034		Lesion, paring/cutting, 2-4	11056	Hep B, ped/adol 3 dose	90744
	Special reports/forms		99080		Lesion, shave	113.....	Hep B-Hib	90748
	Disability/Workers comp		99455		Site: _____ Size: _____		Hib, 4 dose	90645
	Radiology				Nail removal, partial	11730	HPV	90649
					Nail removal, w/matrix	11750	IPV	90713
					Skin tag, 1-15	11700	MMR	90707
	Diagnoses				Medications	Units	Pneumonia, >2 y	90732
	1				Ampicillin, up to 500mg	J0290	Pneumonia conjugal, <5 y	90669
	2				B-12, up to 1,000 mcg	J3420	Td, >7 y	90718
	3				Epinaphrine, up to 1ml	J0170	Varicella	90716
	4				Kanalog, 10mg	J3301	Immunizations & Injections	Units
	Next office visit				Lidocaine, 10mg	J2001	Allergen, one	95115
	Recheck	Prev	PRN	D W M Y	Normal saline, 1000cc	J7030	Allergen, multiple	95117
	Instructions:				Phenergan, up to 50mg	J2550	Imm admin, one	90471
					Progesterone, 150mg	J1055	Imm admin, each add'l	90472
					Rocaphin, 250mg	J0696	Imm admin, intranasal, one	90473
					Testosterone, 200mg	J1080	Imm admin, intranasal, each add'l	90474
	Referral				Tiqan, up to 200 mg	J3250	Injection, joint, small	20600
	To:				Toradol, 15mg	J1885	Injection, joint, intermediate	20605
	Instructions:				Miscellaneous services		Injection, joint, major	20610
							Injection, ther/proph/diag	90772
							Injection, trigger point	20552
	Physician signature						Supplies	
	X							

Appendix 19 – Superbill – Sample

Infectious & Parasitic Diseases

054.9 Herpes simplex, any site
053.9 Herpes zoster, NOS
075 Infectious mononucleosis
034.0 Strep throat
079.99 Viral infection, unspc.
078.10 Warts, all sites

Neoplasms

Benign Neoplasms
239.2 Skin, soft tissue neoplasm, unspc.
216.9 Skin, unspc.

Endocrine, Nutritional & Metabolic Disorders

Endocrine
250.01 Diabetes I, uncomplicated
250.91 Diabetes I, w/ unspc. complications
250.00 Diabetes II, uncomplicated
250.90 Diabetes II, w/ unspc. complications
242.90 Hypert thyroidism, NOS
244.9 Hypothyroidism, unspc.

Metabolic/Other

274.9 Gout, unspc.
272.0 Hypercholesterolemia, pure
272.2 Hyperlipidemia, mixed
278.00 Obesity, NOS
278.02 Overweight

Blood Diseases

285.9 Anemia, other, unspc.

Mental Disorders

300.00 Anxiety state, unspc.
314.00 Attention deficit, w/o hyperactivity
290.0 Dementia, senile, uncomplicated
311 Depressive disorder, NOS

Nervous System & Sense Organ Disorders

Nervous System Diseases
354.0 Carpal tunnel
345.90 Epilepsy, unspc., not intractable
346.90 Migraine, unspc., not intractable

Eye Diseases

372.30 Conjunctivitis, unspc.
368.10 Visual disturbance, unspc.

Ear Diseases

380.4 Earwax impaction
389.9 Hearing loss, unspc.
380.10 Otitis externa, unspc.
382.00 Otitis media, acute

Circulatory System

Arrhythmias
427.31 Atrial fibrillation

Cardiac

413.9 Angina pectoris, NOS
428.0 Heart failure, congestive, unspc.
434.1 Heart valve, aortic, not rheum.
414.9 Ischemic heart disease, chronic, unspc.

Vascular

796.2 Elevated BP w/o hypertension
401.1 Hypertension, benign
458.0 Hypertension, orthostatic
443.9 Peripheral vascular disease, unspc.
451.9 Thrombophlebitis, unspc.
459.81 Venous insufficiency, unspc.

Respiratory System

Lower Respiratory Tract
493.90 Asthma, unspc.
466.0 Bronchitis, acute
496 COPD, NOS
486 Pneumonia, unspc.

Upper Respiratory Tract

462 Pharyngitis, acute
477.9 Rhinitis, allergic, cause unspc.
461.9 Sinusitis, acute, NOS
465.9 Upper respiratory infection, acute, NOS

Digestive System

578.1 Blood in stool
564.00 Constipation, unspc.
562.10 Diverticulosis of colon
562.11 Diverticulitis of colon, NOS
535.50 Gastritis, unspc., w/o hemorrhage
558.9 Gastroenteritis, noninfectious, unspc.
530.81 Gastroesophageal reflux, no esophagitis
455.6 Hemorrhoids, NOS
564.1 Irritable bowel syndrome

Genitourinary System

Urinary System Diseases
592.9 Calculus, urinary, unspc.
595.0 Cystitis, acute
599.70 Hematuria, unspc.
593.9 Renal insufficiency, acute
599.0 Urinary tract infection, unspc./pyuria

Male Genital Organ Diseases

607.84 Impotence, organic
302.72 Impotence, psychosexual dysfunction
601.9 Prostatitis, NOS

Breast Diseases

611.72 Breast lump

Female Genital Organ Diseases

V13.22 Cervical dysplasia, past history
616.0 Cervicitis
622.10 Dysplasia, cervix, unspc.
616.10 Vaginitis/vulvitis, unspc.

Disorders of Menstruation

626.0 Amenorrhea
627.9 Menopausal disorders, unspc.
626.2 Menstruation, excessive/frequent
625.3 Menstruation, painful
626.6 Metrorrhagia

Pregnancy, Childbirth

641.90 Bleeding in preg., unspc.
V24.2 Postpartum follow-up, routine
V22.2 Pregnancy
V22.0 Prenatal care, normal, first pregnancy
V22.1 Prenatal care, normal, other pregnancy

Skin, Subcutaneous Tissue

706.1 Acne, other
702.0 Actinic keratosis
682.9 Cellulitis/abscess, unspc.
682.9 Contact dermatitis, NOS
691.8 Eczema, atopic dermatitis
703.0 Ingrown nail
110.1 Onychomycosis
709.9 Other skin disease, unspc.
696.1 Psoriasis
695.3 Rosacea
706.2 Sebaceous cyst
702.19 Seborrheic keratosis, NOS
707.9 Ulcer, skin, chronic, unspc.
708.9 Urticaria, unspc.

Musculoskeletal & Connective Tissue

General
716.90 Arthropathy, unspc.
729.1 Myalgia/myositis, unspc.
715.90 Osteoarthritis, unspc.
733.00 Osteoporosis, unspc.
714.0 Rheumatoid arthritis (not JRA)
727.00 Synovitis/tenosynovitis, unspc.

Lower Extremity

729.5 Pain in limb

Spine/Torso

724.4 Back pain w/ radiation, unspc.
723.9 Cervical disorder, NOS

Upper Extremity

726.10 Shoulder syndrome, unspc.

Perinatal (Infant)

779.3 Feeding problem, newborn

Signs & Symptoms

789.00 Abdominal pain, unspc.
795.01 Abnormal ECG, ASC-US
719.40 Arthralgia, unspc.
569.3 Bleeding, rectal
786.50 Chest pain, unspc.
786.2 Cough
787.91 Diarrhea, NOS
780.4 Dizziness/vertigo, NOS
787.20 Dysphagia, unspc.
788.1 Dysuria
782.3 Edema, localized, NOS
783.3 Feeding problem, infant/elderly
780.60 Fever, unspc.
771.9 Glucose intolerance
784.0 Headache, unspc.
788.30 Incontinence/enuresis, NOS
782.2 Localized swelling/mass, superficial
785.6 Lymph nodes, enlarged
780.79 Malaise and fatigue, other
787.02 Nausea, alone
787.01 Nausea w/ vomiting
719.46 Pain, knee
724.2 Pain, low back
785.1 Palpitations
788.42 Polyuria
782.1 Rash, nonvesicular, unspc.
782.0 Sensory disturbance skin
786.05 Shortness of breath
780.2 Syncope
788.41 Urinary frequency
787.03 Vomiting, alone
783.21 Weight loss

Injuries & Adverse Effects

Dislocations, Sprains & Strains
845.00 Sprain/strain: ankle, unspc.
845.10 Sprain/strain: foot, unspc.
842.10 Sprain/strain: hand, unspc.
844.9 Sprain/strain: knee/leg, unspc.
847.0 Sprain/strain: neck, unspc.
840.9 Sprain/strain: shoulder/upper arm, unspc.
842.00 Sprain/strain: wrist, unspc.

Other Trauma, Adverse Effects

919.0 Abrasion, unspc.
924.9 Contusion, unspc.
919.4 Insect bite
894.0 Open wound, lower limb, unspc.
884.0 Open wound, upper limb, unspc.

Supplemental Classification

V25.01 Contraception, oral
V25.02 Contraception, other (diaphragm, etc.)
V58.31 Dressing, surgical wound
V01.9 Exposure, infectious disease, unspc.
V72.31 Gynecological exam
V06.8 Immunization, combination, other
V06.1 Immunization, DTP
V04.81 Immunization, influenza
V25.2 Sterilization
V70.0 Well adult check
V20.2 Well child check



Appendix 20 – CMS 1500 – claim form



DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

FICA		FICA	
1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BOX/LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. RESERVED FOR NUCC USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
c. RESERVED FOR NUCC USE		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		b. OTHER CLAIM ID (Designated by NUCC)	
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 _____ DATE _____		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 _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL _____		15. OTHER DATE (MM DD YY) QUAL _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM DD YY) TO (MM DD YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM DD YY) TO (MM DD YY)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	
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		22. RESUBMISSION CODE ORIGINAL REF. NO. _____	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		23. PRIOR AUTHORIZATION NUMBER _____	
26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____	
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.) SIGNED _____ DATE _____	
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____		33. BILLING PROVIDER INFO & PH # () a. NPI b. _____	

Appendix 21 – CMS1500 to 837P – Format Crosswalk

1500 Form Locator		837P		Notes
Item Number	Title	Loop ID	Segment/Data Element	
N/A	Carrier Block	2010BB	NM103 N301 N302 N401 N402 N403	
1	Medicare, Medicare, TRICARE, CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	2000B	SBR09	Titled Claim Filing Indicator Code in the 837P.
1a	Insured's ID Number	2010BA	NM109	Titled Subscriber Primary Identifier in the 837P.
2	Patient's Name	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	Patient's Birth Date, Sex	2010CA or 2010BA	DMG02 DMG03	Sex is titled Gender in the 837P.
4	Insured's Name	2010BA	NM103 NM104 NM 105 NM107	Titled Subscriber in the 837P.
5	Patient's Address	2010CA	N302 N401 N402 N403	
6	Patient Relationship to Insured	2000B 2000C	SBR02 PAT01	Titled Individual Relationship Code in the 837P.
7	Insured's address	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in the 837P.
8	Patient Status	N/A	N/A	Patient Status does not exist in the 837P.
9	Other Insured's Name	2330A	NM103 NM104 N105 N107	Titled Other Subscriber Name in the 837P.

Appendix 21 – CMS1500 to 837P – Format Crosswalk

1500 Form Locator		837P		Notes
Item Number	Title	Loop ID	Segment/Data Element	
9a	Other Insured's Policy or Group Number	2320	SBR03	Titled Insured Group or Policy Number in the 837P.
9b	Other Insured's Date of Birth, Sex	N/A	N/A	Other Insured's Date of Birth and Sex do not exist in the 837P.
9c	Employer's Name or School Name	N/A	N/A	Employer's Name and School Name do not exist in the 837P.
9d	Insurance Plan Name or Program Name	2320	SBR04	Titled Other Insured Group Name in the 837P.
10a	Is Patient's Condition Related to: Employment	2300	CLM11	Titled Related Causes Code in the 837P.
10b	Is Patient's Condition Related to: Auto Accident	2300	CLM11	Titled Related Causes Code in the 837P.
10c	Is Patient's Condition Related to: Other Accident	2300	CLM11	Titled Related Causes Code in the 837P.
10d	Reserved for local use	2300	K3	This is specific for reporting Workers' Compensation Condition Codes.
11	Insured's Policy, Group or FECA Number	2000B	SBR03	Titled Subscriber Group or Policy Number in the 837P.
11a	Insured's Date of Birth, Sex	2010BA	DMG02 DMG03	Titled Subscriber Birth Date and Subscriber Gender Code in the 837P.
11b	Insured's Employer Name or School Name	N/A	N/A	Insured's Employer Name or School Name does not exist in 837P
11c	Insurance Plan Name or Program Name	2000B	SBR04	Titled Subscriber Group Name in the 837P.
11d	Is there another Health Benefit Plan?	2320		Presence of Loop 2320 indicates Y (yes) to the question.
12	Patient's or Authorized Person's Signature	2300	CLM09	Titled Release of Information Code in the 837P.
13	Insured's or Authroized Persons Signature	2300	CLM08	Titled Benefits Assignment Certification Indicator in the 837P.
14	Date of Current Illness, Injury or Pregnancy	2300	DTP03	Titled in the 837P: <ol style="list-style-type: none"> 1. Onset of current illness or injury date. 2. Acute manifestation date. 3. Accident date. 4. Last menstrual period date.
15	If Patient Has Had Same or Similar Illness	N/A	N/A	If Patient Has Had Same or Similar Illness does not exist in 837P.

Appendix 21 – CMS1500 to 837P – Format Crosswalk

1500 Form Locator		837P		Notes
Item Number	Title	Loop ID	Segment/Data Element	
16	Dates Patient Unable to Work in Current Occupation	2300	DTP03	Titled Disability From Date and Work Return Date in the 837P.
17	Name of Referring Provider or Other Source	2310A (referring) 2310D (supervising)	NM103 NM104 NM105 NM107	
17a	Other ID#	2310A (referring) 2310D (supervising)	REF02	Titled Referring Provider Secondary and Supervising Provider Identifier in the 837P.
17b	NPI #	2310A (referring) 2310D (supervising)	NM109	Titled Referring Provider Identifier and Supervising Provider Identifier in the 837P.
18	Hospitalization Dates Related to Current Services	2300	DTP03	Titled Related Hospital Admission Date and Related Hospital Discharge Date in the 837P
19	Reserved for local use	2300	NTE PWK	
20	Outside Lab Charges	2400	PS102	Titled Purchased Service Charge Amount in the 837P.
21	Diagnosis or Nature of Illness or Injury	2300	HI01-2; HI02-2; HI03-2, HI04-2	
22	Medicaid Resubmission and/or Original Reference Number	2300 2300	CLM05-3 REF02	Titled Claim Frequency Code in the 837P. Titled Payer Claim Control Number in the 837P.
23	Prior Authorization Number	2300	REF02	Titled Prior Authorization Number in the 837P.
		2300	REF02	Titled Referral Number in the 837P.
		2300	REF02	Titled Clinical Laboratory Improvement Amendment Number in the 837P.
		2300	REF02	Titled Mammography Certification Number in the 837P.
24A	Date(s) of Service	2400	DTP03	Titled Service Date in the 837P.
24B	Place of Service	2300	CLM05-1	Titled Facility Code Value in the 837P.
		2400	SV105	Titled Place of Service Code in the 837P.

Appendix 21 – CMS1500 to 837P – Format Crosswalk

1500 Form Locator		837P		Notes
Item Number	Title	Loop ID	Segment/Data Element	
24C	EMG	2400	SV109	Titled Emergency Indicator in the 837P.
24D	Procedures, Services or Supplies	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in the 837P.
24E	Diagnosis Pointer	2400	SV107 (1-4)	Titled Diagnosis Code Pointer in the 837P.
24F	\$ Charges	2400	SV102	Titled Line Item Charge Amount in the 837P.
24G	Days or Units	2400	SV104	Titled Service Unit Count in the 837P.
24H	EPSDT/Family Plan	2400	SV111 SV112	Titled EPSDT Indicator and Family Planning Indicator in the 837P.
24I Shaded Line	ID Qualifier	2310B	PRV02 REF01	Titled Reference Identification Qualifier in the 837P.
		2420A	PRV02 REF01	Titled Reference Identification Qualifier in the 837P.
24J Shaded Line	Rendering Provider ID #	2310B	PRV03REF02	Titled Provider Taxonomy Code and Rendering Provider Secondary Identifier in the 837P.
		2420A	PRV03 REF02	Titled Provider Taxonomy Code and Rendering Provider Secondary Identifier in the 837P.
24J	Rendering Provider ID #	2310B	NM109	
		2420A	NM109	Titled Rendering Provider Identifier in the 837P.
25	Federal Tax ID Number	2010AA	REF01 REF02	Titled Reference Identification Qualifier and Billing Provider Tax Identification Number in the 837P.
26	Patient's Account No.	2300	CLM01	Titled Patient Control Number in the 837P.
27	Accept Assignment?	2300	CLM07	Titled Assignment or Plan Participation Code in the 837P.
28	Total Charge	2300	CLM02	Titled Total Claim Charge Amount in the 837P.
29	Amount Paid	2300	AMT02	Titled Patient Amount Paid in the 837P.
		2320	AMT02	Titled Payer Paid Amount in the 837P.
30	Balance Due	N/A	N/A	Balance Due does not exist in the 837P.

Appendix 21 – CMS1500 to 837P – Format Crosswalk

1500 Form Locator		837P		Notes
Item Number	Title	Loop ID	Segment/Data Element	
31	Signature of Physician or Supplier Including Degrees or Credentials	2300	CLM06	Titled Provider or Supplier Signature Indicator in the 837P.
32	Service Facility Location Information	2310C	NM103 N301 N401 N402 N403	
32a	NPI #	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P.
32b	Other ID #	2310C	REF01 REF02	Titled Reference Identification Qualifier or Facility Secondary Identifier in 837P.
33	Billing Provider Info & Ph #	2010AA	NM103 NM104 NM105 NM107 N301 N402 N403 PER04	
33a	NPI #	2010AA	NM109	Titled Billing Provider Identifier in the 837P.
33b	Other ID #	2000A	PRV03	Titled Provider Taxonomy Code in the 837P.
		2010AA	REF01 REF02	Titled Reference Identification Qualifier and Billing Provider Additional Identifier in the 837P.



Appendix 22 – Gateway EDI Clearinghouse – Payer List

Health Plan	Payer ID	Available Transactions	Enrollment Required	Version
Abri Health Plan	ABRI1	Claims Remit Advice Realtime Elig	No Yes No	00501
Servicing States: WI				
American Community Mutual Insurance	60305	Claims Remit Advice	No No	00501
Servicing States: AZ, AR, GA, IL, IN, IA, KS, LA, MI, MO, NE, NC, OH, OK, PA, SC, SD, TN, UT, WI, WY				
AmeriChoice - CT, FL, MD, RI, TX, WI	87726	Claims Remit Advice Realtime Elig Elect COB Realtime Status	No No No No No	00501
Servicing States: CT, FL, MD, RI, TX, WI				
Auxiant	AUX01	Claims Remit Advice Elect COB	No No No	00501
Servicing States: IA, WI				
Beacon Health Strategies - ABRI Health Plan	96019	Claims Remit Advice Elect COB	Yes No No	00501
Servicing States: MA, NH, NJ, NY, WI				
Blue Cross and Blue Shield of Wisconsin	9500	Claims Remit Advice Realtime Elig Elect COB Realtime Status	No No No No No	00501
Servicing States: WI				
Community Connect Health Plan	95192	Claims Remit Advice Elect COB	No No No	00501
Servicing States: WI				

Appendix 22 – Gateway EDI Clearinghouse – Payer List

Health Plan	Payer ID	Available Transactions	Enrollment Required	Version
Dean Health Plan	39113	Claims Remit Advice Elect COB	No No No	00501
Servicing States: WI				
DMERC Region B - CEDI	17003	Claims Remit Advice Realtime Elig Elect COB	No Yes No No	00501
Servicing States: IL, IN, KY, MI, MN, OH, WI				
Group Health Cooperative of Eau Claire	95192	Claims Remit Advice Elect COB	No No No	00501
Servicing States: WI				
Gunderson Health Plan, Inc.	39180	Claims Remit Advice Elect COB	No Yes No	00501
Servicing States: WI				
Health Insurance Risk Sharing Plan - HIRSP	HIRSP	Claims Remit Advice Elect COB	No Yes No	00501
Servicing States: IL, IA, MN, WI				
Independent Care Health Plan (iCARE)	11695	Claims Remit Advice Elect COB	No Yes No	00501
Servicing States: WI				
Managed Health Services Wisconsin	68069	Claims Remit Advice Elect COB	No Yes No	00501
Servicing States: WI				
Medica	94265	Claims Remit Advice Realtime Elig Elect COB Realtime Status	No No No No No	00501
Servicing States: MN, ND, SD, WI				

Appendix 22 – Gateway EDI Clearinghouse – Payer List

Health Plan	Payer ID	Available Transactions	Enrollment Required	Version
Medicaid of Wisconsin - Forward Health	FHWIM	Claims Remit Advice Realtime Elig Elect COB	No No No No	00501
Servicing States: WI				
Medicare of Wisconsin / Wisconsin Physician Serv until 9/7/13 - then lookup NGS	951	Claims Remit Advice Realtime Elig Elect COB	No Yes Yes No	00501
Servicing States: WI				
Midwest Security Insurance Company	MIDSC	Claims Remit Advice Elect COB	No No No	00501
Servicing States: IA, IL, IN, OH, MI, WI				
Molina Healthcare of Wisconsin (formerly Abri)	ABRI1	Claims Remit Advice Realtime Elig	No Yes No	00501
Servicing States: WI				
Network Health Insurance Corporation Medicare	77076	Claims Remit Advice	No Yes	00501
Servicing States: WI				
Network Health Plan	39144	Claims Remit Advice	No Yes	00501
Servicing States: WI				
Physicians Plus Insurance Corporation	39156	Claims Remit Advice Electronic COB	No No No	00501
Servicing States: WI				
Security Health Plan	39045	Claims Remit Advice Electronic COB	No Yes No	00501
Servicing States: WI				

Appendix 22 – Gateway EDI Clearinghouse – Payer List

Health Plan	Payer ID	Available Transactions	Enrollment Required	Version
Tricare North Region	57106	Claims Remit Advice Realtime Elig Elect COB	No Yes No No	00501
Servicing States: CT, DE, DC, IL, IN, KY, ME, MD, MA, MI, MO, NH, NJ, NY, NC, OH, PA, RI, VT, VA, WV, WI				
United Healthcare of Wisconsin, Inc.	87726	Claims Remit Advice Elect COB Realtime Status	No No No No	00501
Servicing States: WI				
Unity Health Plans	66705	Claims Remit Advice Realtime Elig Elect COB	No No No No	00501
Servicing States: WI				
WI Chronic Disease Program - Medicaid of Wisconsin	FHWCD	Claims Remit Advice Electronic COB	No No No	00501
Servicing States: WI				
WI Well Women Program - Medicaid of Wisconsin	FHWWP	Claims Remit Advice Realtime Elig	No No No	00501
Servicing States: WI				
Wisconsin Physician Services Commercial	159	Claims Remit Advice Electronic COB	No No No	00501
Servicing States: IL, IA, MN, WI				



Appendix 23 – WPS Commercial Electronic Claims Enrollment Form

Payer ID: WPS00



WPS Commercial

Wisconsin Physicians Service Corporation

837 and 835

EDI Enrollment Instructions

- ④ Please use the File/Save As command and save this document to your computer then type directly on the forms.
- ④ Complete the forms using the Billing/Group Provider information as credentialed.
- ④ Once completed, save, print and obtain signatures.
- ④ EDI Enrollment processing timeframe with WPS is approximately 14 business days.
- ④ WPS sends enrollment confirmation notices to the provider.

837 Claim Transactions

1. Provider Agreement to Submit Electronic Media Claims, 3 pages.

835 Electronic Remittance Advice

1. WPS Commercial Provider Authorization for WPS Electronic Remittance Advice, 2 pages.

Submit Completed Documents

1. Fax all pages of completed documents to WPS ○ 608-223-3824
2. Fax all pages of completed documents to ClaimRemedi ○ 707-573-1066



Wisconsin Physicians Service Insurance Corporation
 1717 W. Broadway
 P.O. Box 8190
 Madison, WI 53708-8190
 Phone: (608) 221-4711

Dear WPS Provider:

Reminders:

Complete and return all 3 pages

Enrollment@ClaimRemedi.com

Fax: 707-573-1066 Thank

you for choosing the electronic method for submission of your healthcare claims. Wisconsin Physicians Service requires that all new electronic providers/groups sign, and have on file, a "Provider Agreement to Submit Electronic Media Claims" prior to submitting electronic claims. We request that you complete and return this agreement form, including this cover letter, to our office.

An organization that has several providers can execute a single Provider Agreement form on behalf of the group. Only one authorizing individual is needed to sign the agreement for the Clinic/Group. (Note: A separate agreement is required for each Tax ID.)

In addition to the agreement, the following information is needed (please print):

Clinic Tax ID:	Clinic NPI Number(s):
Physician/Clinic/Institution Name:	
Address:	
City/State/Zip:	Billing Service/Clearinghouse (if applicable):
Contact Name:	Phone Number:
Contact e-mail address:	Fax Number:
Provider/clinic/institution physical location(s) address:	
<i>NOTE: If you have multiple physical locations, please attach a list including the associated billing and NPI address for each</i>	

Please indicate your EDI submission option:

Name of Billing Service/Clearinghouse (if applicable): _____

Direct Filing via WPS Bulletin Board System or Internet Batch (using vendor supplied EDI software program and transmitting from your site) **Name of Vendor if Billing direct (if applicable):**

- If this option is selected, please register as a submitter through the WPS Trade Partner System (WTPS) at <https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>.
 - If you have already registered as a submitter, please provide the submitter number assigned _____.
 - If you need assistance with registration, please contact WPS Electronic Data Services at 800-782-2680, option 4.
- PC-Ace software – Free claims submission software supplied by WPS**

Please indicate your method of transmission if sending Direct:

_____ **WPS-batch Internet claim submission**

_____ **WPS Bulletin Board System**

*Please note: A faxed, e-mailed faxed image or original will be accepted. Please mail, fax or e-mail your completed agreement to:

WPS Electronic Data Services
 WPS Insurance Corporation
 P.O. Box 8128
 Madison, WI 53708-8128
Fax (608) 223-3824
E-Mail Address: edi@wpsic.com

Note: If you are a new provider/location or have recently changed your physical or billing address, it is important that WPS update our provider file before you submit your EDI Provider Agreement. Please contact WPS/EPIC Member Services at 1-800-765-4977 for in-state providers or 1-800-356-8051 for out-of-state providers. You can also fax your updated information to 608-221-6161.

=====
=====
For Office Use Only

BL(s) _____, _____, _____, _____

Sub # _____ CH _____ Direct _____ CTY _____

EACV: _____ WC _____ G _____ M _____ C _____ S _____

EXHIBIT A

**PROVIDER AGREEMENT TO SUBMIT
ELECTRONIC MEDIA CLAIMS
FOR REIMBURSEMENT BY
WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION**

It is hereby agreed between Wisconsin Physicians Service Insurance Corporation (hereinafter referred to as WPS), and the undersigned health care provider, (hereinafter referred to as "Provider"), that said Provider is appointed to submit claims via electronic media for reimbursement by WPS for services rendered to WPS health plan subscribers and dependents. This appointment is conditioned upon the Provider fully agreeing to and following all of the terms and conditions set forth in this Agreement, the Attachment A as applicable and clearing WPS internal provider review standards for acceptance and payment of EMC submitted claims.

TERMS AND CONDITIONS

1. In submitting Electronic Media Claims, Provider agrees to submit such claims edited and formatted according to the specifications indicated within the user's guide supplied by WPS. Provider understands the WPS EMC user's guide is proprietary and is authorized for use only by Provider and its employees working on its behalf to submit such electronic media claims. Any other use or distribution of the WPS EMC user's guide is strictly prohibited without the express written consent of WPS. WPS shall be the final authority in resolving any discrepancies in how electronic data shall be submitted.
2. Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered signed by the Provider or Provider's authorized representative.
3. Provider agrees to maintain a patient signature file. Provider understands WPS may validate through file audits, those claims submitted via electronic media which are included in any quality control or sampling method requested by WPS. Provider understands if no signed authorization is on file, an authorization must be obtained prior to claim submission.
4. Provider agrees that WPS or representatives of WPS, have the right to audit and confirm any source documents, including, but not limited to, medical records, claim forms, and Explanation of Benefits from Primary Carriers, that are relevant to claims submitted to WPS electronically. Any incorrect payments which are discovered as a result of such an audit will be appropriately adjusted.
5. Provider will ensure that each electronic media claim submitted can be readily associated with all source documents in an auditable fashion for no less than seventy-two (72) months following the date of payment by WPS. All medical records will be maintained according to the laws of the state in which the services are provided.
6. Provider agrees to establish and maintain procedures so that information concerning WPS subscribers and dependents or any information obtained from WPS shall not be used by Provider or Provider's agents, officers or employees except as provided by Federal or State Law including the Freedom of Information Act, Drug Abuse Office and Treatment Act (42 U.S.C. s290ee-3) and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (42 U.S.C. s290dd-3). Provider agrees not to disclose any information concerning a WPS subscriber to any person or organization other than WPS, without the express written permission of the WPS subscriber or his lawful representative.
7. The undersigned provider understands that the submission of an electronic media claim to WPS is a claim for WPS payment and that any misrepresentation or falsification of records relating to that claim is Subject to prosecution under federal criminal and civil law and the laws of the State of Wisconsin and, upon conviction, will result in fines and/or imprisonment.

8. This agreement may be terminated at any time by either party to this Agreement by giving five (5) days written notice of such termination to the other party.
9. Provider agrees that WPS may test any submission against validity and consistency edits as defined in the user's guide provided by WPS. Provider understands that WPS will accept all valid claims which meet such edit requirements and return such errant submissions for correction.

In the event that errors are identified on claims which pass these edits and have been accepted into the WPS adjudication system, WPS will work with the Provider to remedy such errors. However, data errors submitted by Provider will be identified to the Provider in writing by WPS and Provider will remedy such errors within five (5) working days or face possible suspension from the EMC program or termination of this Agreement.

10. WPS reserves the right to refuse for any reason to accept electronic media claims covered by this Agreement.
11. All required notices under this Agreement shall be sent by certified mail, postage prepaid, return receipt requested.

The signed agreement or any questions related to the agreement shall be mailed to:

Wisconsin Physicians Service
Electronic Data Service
PO Box 8128
1717 W. Broadway
Madison, WI 53708-8128

If such notice is sent to the Provider, it will be addressed to the individual named in the Provider's signature blank below, and sent to the mailing address shown below for the Provider.

12. This Agreement may not be modified or changed orally. All modifications must be made in writing signed by both parties.
13. The interpretation and legal effect of this Agreement shall be governed by the laws of the State of Wisconsin.
14. This Agreement shall be binding upon, and inure to the benefit of the successors, assigns and legal representatives of each of the parties hereto. However, it shall not be assigned by either party without the written consent of the other party.
15. It is agreed that the relationship of the parties hereto is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.
16. By executing this Agreement below, Provider agrees to all of the terms and conditions of the Agreement. Provider further agrees to begin to submit claims electronically only after Provider has received a written notice from WPS stating permission to do so has been granted.

WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION

Name of Provider

Tax ID Number of Provider

NPI Number of Provider

Mailing Address

By _____
Signature and Title of Provider
or Authorized Officer

By _____
WPS Authorized Signature

Date 09/06/12

Date



**WPS COMMERCIAL
PROVIDER AUTHORIZATION FOR WPS
ELECTRONIC REMITTANCE ADVICE**

Due to HIPAA requirements, only one submitter ID per provider number may be established for ERA. The submitter ID on this request will be the only recipient of ERA for the provider(s) listed.

*Check all lines of business that apply:

WPS Commercial _____ MCDFC _____ CCCW _____ CLTS _____ HIRSP _____ RAKE _____
Southwest Family Care Alliance _____ Northern Bridges _____ LCD _____

*NOTE - TRICARE providers should use the appropriate TRICARE ERA request form.

ERA	PROVIDER	INFORMATION
The only version of electronic remittance available is 5010A1.		
*PROVIDER/FACILITY NAME: _____		
*PROVIDER/FACILITY TAX ID: _____		

Please choose only one option below:

_____ **Tax ID** Choose this option if you want all locations under this Tax ID set up for Electronic Remittance. All Electronic Remits for the Tax ID provided will be sent to the Receiver ID provided on Page 2.

OR

_____ **Specific Location Pay To/Payment Location(s)** Choose this option for a specific location(s) and list them below. All Electronic Remits for the Tax ID, physical and Payment address(s) provided will be sent to the Receiver ID provided on Page 2. If you have additional locations, please attach. Please include **Pay To/Payment Address**.

PHYSICAL LOCATION

*PAYMENT LOCATION

- | | | |
|----|-------|-------|
| 1. | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| 2. | _____ | _____ |
| | _____ | _____ |

If you add an additional service location in the future and wish to receive ERA for this new location, go to our EDI web site at http://www.wpsic.com/edi/pdf/edi_ern_wps.pdf download another form.

***REQUIRED**

Page 1 of 2



09/06/2012

ERA REQUESTER INFORMATION

***Print Provider Authorized Contact/Requestors Name:** _____

***Authorized Contact/Requestors Phone# / Email Address:** _____

***Authorized Signature:** _____ ***Date:** _____

EDI CLAIM INFORMATION

Who submits your EDI claims? Submitter #: _____

ERA RECEIVER INFORMATION

If you don't use a clearinghouse and receive your ERAs directly, what is your Receiver ID: _____

If you wish to receive ERAs (ANSI 835 file) direct to your office and you haven't already, please register for a trading partner/ERA receiver number at: <https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>.

Place 5 digit assigned trading partner number in the field: _____

If you don't know your Clearinghouse Receiver ID, contact your Clearinghouse.

***Billing Service/Clearinghouse Name:** _____

Contact Name: _____

Contact Phone #: _____

Contact Email address: _____

Date to begin ERA: _____

An original or faxed copy will be accepted. Please mail or fax your completed agreement to:

Wisconsin Physicians Service
Electronic Data Service
P.O. Box 8128
Madison, WI 53708-8128
Fax (608-) 223-3824
EDI@wpsic.com

***REQUIRED**



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Wisconsin Department of Health Services
Division of Public Health

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