Healthy Connections

PROVIDER MANUAL

Hospital Services

Established April 1, 2005
Updated May 1, 2019

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.dhhs.state.sc.us

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MEDICAID BULLETIN

TO: **Hospital Services Providers**

SUBJECT: **Medicaid Policy Manual for Hospital Services Providers**

The enclosed revised Hospital Services Medicaid Provider Manual is effective April 1, 2005 and includes all previous HIPAA changes and Medicaid policy bulletins.

This manual is to be used for program information and requirements, billing procedures, and provider services guidelines. **Due to several substantial changes in policy, providers are urged to carefully review this revision.**

In addition to inclusion of policy changes specific to the Hospital Services program area, the new provider manuals for all Medicaid programs have been reformatted to give them a more consistent, standardized layout and to improve navigation and readability. Headings for each subsection appear on the left side of the page, with the corresponding information on the right. "Chapters" are now called "sections," and the numbering system has been simplified.

The revised manual is organized as follows, with each section having its own table of contents:

Section 1, **General Information and Administration,** contains an overview of the South Carolina Medicaid program, as well as information about record retention, documentation requirements, utilization review, program integrity, and other general Medicaid policies.

Section 2, **Policies and Procedures,** describes policies and procedures specific to the Hospital Services program.

Section 3, **Billing Procedures,** contains billing information that is common to all South Carolina Medicaid programs, as well as program-specific guidelines for claim filing and processing.

Section 4, **Billing Codes,** contains reimbursement types for the outpatient fee schedule, PPS DRG relative weights for inpatient billing, revenue codes, and a list of codes that require prior authorization and support documentation.

Section 5, **Administrative Services**, contains contact information for DHHS state and county offices, as well as program areas throughout DHHS, and examples of all forms referenced throughout the manual.

The **appendices** include the following:

- Edit Codes, Claim Adjustment Reason Codes (CARCs) & Remittance Advice Remark Codes (RARCs), and Resolutions
- Carrier Codes
- Schedule of Copayments

The enclosed compact disc contains a copy of the manual in Portable Document Format (pdf). To access the file, you will need Adobe Acrobat Reader software, which is pre-installed on most computers and also available for free download at **www.adobe.com/support**.

The most current version of the provider manual is maintained on the DHHS Web site at **www.dhhs.state.sc.us**. [From the DHHS home page, scroll down and click on the link for Resource Library; next, click on the link for Manuals, and scroll down to the listings located beneath the heading Service Providers.]

Should you wish to order a printed copy of your provider manual, or an additional compact disc, please call South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing.

The policy manual and fee schedule are not subject to copyright regulations and may be reproduced in their entirety.

If you have any questions regarding this provider manual and fee schedule, please contact your Hospital Services program coordinator at (803) 898-2665. Thank you for your continued support of the South Carolina Medicaid program.

Robert M. Kerr
Director

RMK/bgaw

Enclosures

NOTE: To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.dhhs.state.sc.us/ResourceLibrary/E-Bulletins.htm

GENERAL TABLE OF CONTENTS

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-19	Forms	-	Replaced Consent for Sterilization form with 04/30/2022 version
04-01-19	1	35	Updated Prepayment Reviews
04-01-19	Forms	-	Replaced Consent for Sterilization form with April 2019 version
04-01-19	Appendix 1	56	Updated edit codes 906 and 907
03-01-19	Forms	-	Replaced Consent for Sterilization form with March 2019 version
03-01-19	Appendix 2	-	Updated carrier codes
02-01-19	Forms	-	Replaced Consent for Sterilization form with new version (#0937-0166 Expiration 02/28/19)
01-03-19	Forms	-	Replaced Consent for Sterilization form
01-01-19	4	99-102 131, 139-143	Updated procedure code descriptions in the following sections: • PT, OT, and Speech Therapy CPT Codes • Family Planning CPT/HCPCS Services
12-01-18	Appendix 2	-	Updated carrier codes
11-01-18	Forms	-	Updated Claim Reconsideration Form
11-01-18	Appendix 1	55-56	Updated edit codes 906 and 907
10-01-18	2	-	Incorporated the 2018 ICD-10 update
10-01-18	Appendix 1	44, 55-56, 64-65	Updated edit codes 820, 906, 907, and 977
08-06-18	1	25	Updated Premium Payment Project
08-06-18	TPL Supplement	17-18	Updated TPL Resources
08-01-18	4	1 2	• Updated Reimbursement Type 1 — Surgical • Updated Reimbursement Type 5 — Non-Surgical

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-18	Appendix 2	-	Updated carrier codes
08-01-18	Managed Care Supplement	-	Updated entire section
07-01-18	3	55-56 56	• Updated Retro Medicare • Updated Retro Health
07-01-18	Appendix 1	3, 37, 42, 45, 52-57, 70, 73 48 66-67	• Updated CARC and RARC for edit codes 059, 710, 738, 739, 757, 820, 821, 837, 838, 839, 843, 844, 912, 914, 928, 934, and 952 • Updated CARC for 786 • Updated Resolution for 906 and 907
07-01-18	TPL Supplement	15-16 17	• Updated Retro Health and Pay & Chase • Updated TPL Resources
06-01-18	2	 10 15 31-32 33	Updated the following sections: • Prior Authorization • Prior Authorizations for Inpatient Admissions • Long Acting Reversible Contraceptives (LARCs) • Adult Nutritional Counseling
05-01-18	2	 32 61	Updated the following sections to remove ICD-9 codes and refer providers to the Hospital Provider Manual webpage • Long Acting Reversible Contraceptives (LARCs) • Billing Notes for Abortions
05-01-18	4	74, 123, 125, 149, 153	Updated section to remove ICD-9 codes and refer providers to the Hospital Provider Manual webpage
05-01-18	Forms	-	Updated Claim Reconsideration Form
05-01-18	Appendix 2	-	Updated carrier codes
05-01-18	Webpage	-	Added ICD-9 codes
04-01-18	3	49	Updated Examples, Reimbursement Type C - Cost Outlier
03-01-18	4	151	Family Planning CPT/HCPCS Services

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-18	Forms	-	Updated Health Insurance Information Referral Form (DHHS Form 931)
02-01-18	Appendix 2	-	Updated carrier codes
01-01-18	2	7-8 23 24 31, 75	Updated the following sections: • Medicare/Medicaid (Dually Eligible) • Updated A. Outpatient Surgical Services — Reimbursement Type 1 • B. Outpatient Non-Surgical Services — Reimbursement Type 5 • Long Acting Reversible Contraceptives (LARCs)
01-01-18	4	72 101, 104-105 107 134, 149, 150	Updated the following tables: • Outpatient Hospital Surgeries CPT Codes • PT, OT, and Speech Therapy CPT Codes • Outpatient Hospital Services • Family Planning CPT/HCPCS Services
01-01-18	5	1	• Updated Correspondence and Inquiries
12-01-17	2	32, 75	Updated Long Acting Reversible Contraceptives (LARCs)
12-01-17	4	155	Updated Family Planning CPT/HCPCS Services
12-01-17	Forms	-	• Updated Claim Reconsideration Form
11-01-17	4	127 135	• Deleted Family Planning Procedure Codes • Updated Family Planning CPT/HCPCS Services
11-01-17	Appendix 2	-	Updated carrier codes
10-01-17	2	33-35 46	• Updated Long Acting Reversible Contraceptives (LARCs) – ICD-10 PCS • Updated Hospital Acquired Conditions (HACs), Other Provider Preventable Conditions (OPPCs), and Never Events (NEs) – ICD-10 2017
10-01-17	4	75	• Updated ICD-10-PCS Prior Authorization Codes • Updated ICD-10-PCS Surgical Codes

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-17	Webpage	-	Updated OP Reimbursement Levels
10-01-17	Appendix 1	-	Added new edit code 063
09-01-17	Forms	-	Updated Claims Reconsideration, Duplicate Remittance Advice Request, and Electronic Funds Transfer (EFT) Authorization Agreement forms
08-01-17	2	23 25	• Updated A. Outpatient Surgical Services — Reimbursement Type 1 • Updated B. Outpatient Non-Surgical Services — Reimbursement Type 5
08-01-17	4	1	• Updated Reimbursement Type 1 — Surgical • Updated Reimbursement Type 5 — Non-Surgical
08-01-17	Forms	-	Updated Surgical Justification Review for Hysterectomy (form and sample)
08-01-17	Appendix 2	-	Updated carrier codes
06-01-17	2	54 55 58 73	Updated the Consent for Sterilization Form number reference in the following sections: o Hysterectomy o Elective Sterilization o Sterilization Consent Form Requirements o Sterilization
06-01-17	Forms	-	• Updated Claim Reconsideration Form • Updated DHHS Form 687, formerly DHHS Form 1723 (Consent for Sterilization)
06-01-17	Appendix 2	-	Updated carrier codes
05-01-17	2	53-54 64-65 73 75 81	Updated the following sections: • Physician Services • Panniculectomy • Family Planning Services, Covered Services • Family Planning Services, Non-Covered Services • Long Acting Reversible Contraceptives (LARCs) • Billing Notes for Sterilization and Other Related Procedures • Consent for Sterilization Form, Non-Covered

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Services
05-01-17	4	68 85-86 94 103 110 133 134 140 138	• Updated the following sections: o ICD-9-PCS Prior Authorization Codes, formerly ICD-9-CM Prior Authorization Codes o PT, OT, and Speech Therapy CPT Codes o ICD-9-PCS Surgical Codes, formerly ICD-9-CM Surgical Codes o ICD-10-PCS Surgical Codes, formerly ICD-10-CM Surgical Codes o Family Planning Procedure Codes o Family Planning CPT/HCPCS Services o Inpatient Hospital ICD-9-PCS Non-Elective Abortion Surgical Procedure Codes, formerly Inpatient Hospital ICD-9-CM Non-Elective Abortion Surgical Procedure Codes o Inpatient Hospital ICD-10-PCS Non-Elective Abortion Surgical Procedure Codes, formerly Inpatient Hospital ICD-10-CM Non-Elective Abortion Surgical Procedure Codes o Inpatient Elective Therapeutic Abortion ICD-10-CM Diagnosis Codes, formerly Inpatient Elective Therapeutic Abortion ICD-10-CM Surgical Codes o Inpatient Elective Therapeutic Abortion ICD-9-PCS Surgical Codes, formerly Inpatient Elective Therapeutic Abortion ICD-9-CM Surgical Codes • Added Inpatient Elective Therapeutic Abortion ICD-9-CM Diagnosis Codes
05-01-17	Appendix 1	1	Updated Provider Service Center Hours of Operation
04-04-17	Forms	-	• Updated Request for Medicaid ID Number – Infant Form
03-01-17	Forms	-	• Updated Claim Reconsideration Form
02-08-17	2	31-33	Updated Long Acting Reversible Contraceptives (LARCs)
02-08-17	4	69, 78	Updated ICD-10-PCS Prior Authorization Codes

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-17	Webpage	-	Updated OP Reimbursement Levels
02-01-17	Appendix 2	-	Updated carrier codes
01-01-17	2	7 15 30, 31	Update the following sections: • Medicare/Medicaid (Dually Eligible) • Prior Authorization for Inpatient Admissions • Updated Long Acting Reversible Contraceptives (LARCs) section
01-01-17	4	64, 65 86-89 111, 112, 124, 125	Updated the following tables: • Billing Codes Requiring Prior Authorization • PT, OT, and Speech Therapy CPT Codes • Billing Codes for Family Planning
12-01-16	3	10 12	• Updated Procedural Coding section • Updated Diagnostic Codes section
12-01-16	Forms	-	• Updated Claim Reconsideration Form • Re-inserted Request for Prior Approval Review By KePRO form
11-01-16	Appendix 2	-	Updated carrier codes
10-01-16	1	5-6	Deleted SC Healthy Connections Checkup Program language and moved sample Checkup card to South Carolina Healthy Connections Medicaid Card section
10-01-16	2	32, 33, 45 70	• Updated ICD-10 CM codes • Updated Checkup and Family Planning Services Section
10-01-16	3	21	Updated Medicaid Copayments Section
10-01-16	4	69-77, 100-101 91-113	• Updated ICD-10 CM codes • Updated Billing Codes for Checkup and Family Planning Section
09-01-16	2	24	Updated C. Treatment/Therapy/ Testing (TTT) Services — Reimbursement Type 4
09-01-16	Appendix 1	67	Updated edit code 979

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
09-01-16	Appendix 2	-	Updated carrier codes
08-01-16	1	2, 4, 5, 24, 27	Updated to reflect Medicaid Bulletin dated July 11, 2016 – New Medicaid Cards
08-01-16	Appendix 1	22, 23, 66	Updated edit codes 527, 532, and 965
07-01-16	2	33-34, 61	Updated the following sections to reflect Medicaid Bulletin dated June 9, 2016 – Coverage of Bariatric Surgery: • Adult Nutritional Counseling • Bariatric Surgery (formerly Gastric Bypass)
07-01-16	Appendix 1	3, 65	Updated edit codes 062 and 974
06-01-16	4	91 111	• Checkup and Family Planning Procedure Codes • Updated Checkup and Family Planning CPT Services
06-01-16	5	- 1 3	• Updated hyperlinks throughout section • Updated Administration section • Updated Procurement of Forms section
06-01-16	Appendix 1	44 3, 14, 29, 30, 63	Added new edit codes 801 and 802 Updated CARC for edit codes 079, 356, 357, 605, 693, and 958
05-01-16	2	30-31, 71	Updated Long Acting Reversible Contraceptives (LARCs)
05-01-16	4	65 91 111	Updated the following sections: • Revised code descriptions for 57291 and 57292 • Checkup and Family Planning Procedure Codes • Billing Codes for Checkup and Family Planning
05-01-16	Appendix 1	6, 63, 67	Updated edit codes 150, 953, 989, 990
05-01-16	Appendix 2	-	Updated carrier codes
04-01-16	Managed Care Supplement	18-19	Replaced sample MCO cards
03-01-16	4	2	Updated rate for revenue code 440

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-16	Appendix 1	19, 23	Added edit codes 450 and 532
02-01-16	1	-	Updated the following sections to reflect Medicaid Bulletin dated January 26, 2016 – Updates to Section 1 – All Provider Manuals: • South Carolina Medicaid Program o Program Description o SC Healthy Connections Medicaid Card(s) • Records/Documentation Requirements o General Information o Signature Policy • Medicaid Program Integrity o Program Integrity • Appeals
02-01-16	4	-	Corrected headers
01-01-16	1	19	Updated to reflect Medicaid Bulletin dated December 9, 2015 - Charge Limits
01-01-16	Appendix 1	21	Added edit code 527
12-01-15	Cover	-	December 1, 2015 - Replaced manual cover
11-04-15	3	39	Updated Remittance Advice Items to add Y claim type to field D
11-04-15	4	19-62	Replaced APR-DRGs and Relative Weights table
11-01-15	Appendix 1	19, 44-47	• Revised edit code 507, 821, 837, 838, 839
10-01-15	1	7 10	• Updated to add SCDHHS alerts • Updated Provider Participation
10-01-15	2	30-32 57	• Added Long Acting Reversible Contraceptives (LARCs) • Updated Billing Notes for Abortions
10-01-15	3	10	Updated Procedural Coding
10-01-15	Appendix 1	1	• Updated general instructions • Updated the following to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		1 All 4, 20, 23, 27, 43	o Added note to general instructions o Replaced ICD-9 with ICD-CM throughout section • Deleted edit codes 102-109, 112-116, 503, 527, 566, 791, 792
09-01-15	2	 18 40 55-56 66	Updated the following sections to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System: • Mother/Newborn Admissions • Hospital Acquired Conditions (HACs), Other Provider Preventable Conditions (OPPCs), and Never Events (NEs) • Billing Notes for Abortions • Non-Covered Services
09-01-15	3	7 10 12 12 23 30 42-43 60	• Updated SC Medicaid Web-based Claims Submission Tool to reflect Medicaid Bulletin dated June 19, 2015 — Claim Submission Web Portal (Webtool) Enhancement SC Medicaid Web-based Claims Submission Tool • Updated the following sections to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System: o Procedural Coding o Diagnostic Codes o Present On Admission (POA) Indicator o Billing Instructions for Service Provided as the Result of an Emergency o Completion of the UB-04 Claim Form – field 67 o Remittance Advice Items – field M o UB-04 Data Fields – field 67
09-01-15	4	68-120	• Adding/updated procedure codes to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System • Updated OP Reimbursement Levels (Hospital webpage) to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
09-01-15	Appendix 1	5, 14	• Added edit codes 270 and 271 • Updated to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System
08-01-15	2	30-32 60	• Updated reflect Medicaid Bulletin dated July 2, 2015 – Nutritional Counseling and Dietitian Enrollment • Updated Positron Emission Tomography (PET) Scans
07-01-15	Appendix 3	1-2	Updated Copayment Schedule
06-01-15	4	67	Added procedure code 64568 to Outpatient Hospital Surgeries CPT Codes
03-13-15	3	7	Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
03-02-15	4	77-93	Added Checkup and Family Planning CPT/HCPCS Services
03-01-15	Appendix 2		Updated carrier codes
02-01-15	2	7	Updated Medicare/Medicaid (Dually Eligible)
01-01-15	Forms		Updated the following forms: • Claim Reconsideration • Request for Medicaid ID Number - Infant
12-01-14	1	9, 10	Updated Provider Participation to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
12-01-14	3	3-4 36-37	Added the following policies: • Copayment • Claim Reconsideration
12-01-14	Forms		Added Claim Reconsideration form
12-01-14	Appendix 1	6, 50	Updated edit codes 121 and 839
12-01-14	Appendix 3	1-2	Updated Copayment Schedule

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12-01-14	Managed Care Supplement	2	Updated Managed Care Organizations (MCOs) to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
11-01-14	Appendix 1	70	Updated edit code 989
10-01-14	1	33-34	Updated Medicaid Beneficiary Lock-In Program
10-01-14	Appendix 1	3, 31, 36, 48-49, 61 46	• Updated edit code 079, 637, 719, 820, 821, 908, 909 • Added new edit code 790
09-01-14	4	14	Added revenue codes 780 and 789
08-01-14	1	6	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	2	66 66-74	• Deleted Family Planning Waiver • Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	3	20	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	4	75	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	Appendix 1	51, 69 24, 48-51, 58	• Deleted edit codes 845 and 969 • Updated edit codes 537, 837-839, 843, 844, and 892
07-01-14	2	35-40	Updated to reflect Medicaid Bulletin dated May 23, 2014 – Provider Preventable Conditions Policy
07-01-14	Appendix 1	15	Updated resolution for edit code 349, 369, 509
06-01-14	Forms	-	Updated Out-of-State Referral Package
06-01-14	Appendix 1	3, 12	Updated resolutions for edit codes 079, 227, and 239

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
06-01-14	Appendix 2	All	Updated carrier codes
05-06-14	2	20	Added Transportation of Self-Administered Oxygen Dependent Beneficiaries section to reflect Medicaid Bulletin dated May 1, 2014
05-01-14	General Table of Contents	1	Removed DHHS county office listing
05-01-14	2	20, 22, 23, 28 18	• Replaced procedure code J1055 with J1050 • Replaced reference to county office listing with the Where To Go for Help web address
05-01-14	3	30	Replaced procedure code J1055 with J1050
05-01-14	4	1, 2, 75	Replaced procedure code J1055 with J1050
05-01-14	5	1 5	• Replaced reference to county office listing with the Where To Go for Help web address • Removed DHHS county office listing
05-01-14	Appendix 1	1, 2, 4, 45, 46, 62, 64, 92, 93	Updated edit codes 007, 052, 079, 715, 719, 837, 839, 977, 984
04-01-14	Change Control Record	3	Deleted CMS-1500 changes from January 1, 2014 for sections 3 and Forms
04-01-14	1	6, 23, 25 29-31 32 33 37 39 41-44	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated the following sections: o Program Integrity o Recovery Audit Contractor o Beneficiary Oversight o Fraud o Referrals to the Medicaid Fraud Control Unit o Updated acronym for U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG)

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
04-01-14	2	28	Deleted Prior Authorization for High-Tech Radiology
04-01-14	3	1-56 4 5	• Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated Trading Partner Agreement • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
04-01-14	4	67 69	• Deleted High-Tech Radiology procedure codes • Deleted ICD-9 code V59.02
04-01-14	5	10	Updated Horry County address
04-01-14	Forms		• Updated Reasonable Effort Documentation and Duplicate Remittance Advice Request forms • Removed Sample Edit Correction Form • Updated Sample Remittance Advice
04-01-14	Appendix 1	35 -	• Added edit code 527 • Entire section: o Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form o Updated to reflect Medicaid Bulletin dated November 30, 2013 – Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version
04-01-14	TPL Supplement	 5 6-8 9-10 10-11 13-14 15-16 22-23 30-31	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form: o Timely Filing Requirements o Reasonable Effort o Nursing Facility Claims o Professional, Institutional, and Dental Claims o Rejected Claims o Recovery o Sample Forms – Reasonable Effort o Sample Forms – ECF (deleted)
03-01-14	4	69 69, 70	• Deleted ICD-9 codes 39.31 and 45.62 • Added ICD-9 codes 52.83 and V59.02

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-14	Cover	-	January 1, 2014 - Replaced manual cover
02-01-14	5	9	Updated Florence County office telephone number
01-01-14	1	1, 2, 11 6, 23, 25 1-2 4 6 26 29-30 32 32	Updated to reflect the following bulletins: • Managed Care Organizational Changes dated November 15, 2013 • Discontinuation of Edit Correction Forms (ECFs) dated December 3, 2013 Updated the following sections: • Eligibility Determination • South Carolina Health Connections Medicaid card • South Carolina Web-based Claims Submissions Tool • Retroactive Eligibility • Program Integrity • Recovery Audit Contractor • Beneficiary Explanation of Medical Benefits Program
01-01-14	2	5, 70 7	Updated to reflect the following bulletins: • Managed Care Organizational Changes dated November 15, 2013 • 2014 Medicare Deductible, Coinsurance and Medicaid Blood Deductible Rates for Dually Eligible Medicaid Members
01-01-14	3	-	Updated entire section to reflect the following bulletins: • Discontinuation of Edit Correction Forms (ECFs)s dated December 3, 2013 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	5	1 3-4	Updated the following sections • Correspondence and Inquiries • Procurement of Forms
01-01-14	Forms		• Updated Duplicate Remittance Advice Request and EFT Authorization Agreement forms
01-01-14	Appendix 1		Updated to reflect the following bulletins: • Discontinuation of Edit Correction Forms (ECFs)s

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			dated December 3, 2013 • Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	Managed Care Supplement		Updated to reflect bulletin Managed Care Organizational Changes dated November 15, 2013
01-01-14	TPL Supplement		• Updated to reflect bulletin Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014
12-01-13	5	12	Updated Orangeburg mailing address zip codes
11-01-13	2	7	Updated Medicare/Medicaid (Dually Eligible) information to reflect Medicaid Bulletin dated February 8, 2013.
11-01-13	5	13	Updated York County mailing address
11-01-13	MC Supplement	18	Replaced BlueChoice MCO Medicaid card
10-01-13	5	12 13	• Updated Orangeburg office and mailing address • Updated York County office address
10-01-13	Appendix 1	- 5, 39 69 37, 42, 44	• Updated CARCs/RARCs throughout section • Added edit codes 110 and 725 • Deleted edit code 961 • Revised edit codes 720, 749, 750, 758, and 759
10-01-13	MC Supplement	20	• Added WellCare MCO Medicaid card and contact information
09-01-13	5	8 11 13	• Updated Darlington County zip code • Updated Laurens County phone number • Updated York County office address
08-01-13	5	13	• Updated York County physical address
08-01-13	Appendix 1	1	• Updated resolution for edit code 007

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		50, 51 72	• Updated RARC and resolution for edit codes 820 and 821 • Deleted edit codes 954, 955, and 956
08-01-13	Appendix 2	All	Updated carrier codes
07-01-13	5	8 12	• Updated Colleton County office telephone number • Deleted Newberry County PO Box address
06-01-13	5	12	• Updated Richland county office telephone number
06-01-13	Appendix 1	5, 11, 15, 33, 40 30	• Updated resolutions for edit codes 107, 219, 339 673, 720 • Deleted edit code 577
04-01-13	1	6	Corrected the URL for MedicaideLearning.com
04-01-13	Appendix 1	2 20, 25, 28 4, 39, 52, 53, 57, 59 73 50, 51 67, 69	• Changed edit code description reference DMR and MR/RD to ID/RD for edit code 052 • Updated CARCs for edit codes 460, 544, 569 • Updated resolutions for edit codes 079, 722, 837, 838, 855, 865, 960 • Added edit codes 820, 821 • Updated edit code 935, 938, 939
04-01-13	Appendix 2	-	Updated carrier code list
03-01-13	3	19	Changed ICF/MR to IID
03-01-13	5	10	Deleted Jasper County PO Box address
03-01-13	Appendix 1	i 2, 38, 70 38, 54, 70	Deleted Change Log Changed edit code description reference to DMR and MR/RD to ID/RD for edit codes 052, 053, 712, and 953 Updated resolutions for edit codes 714, 851, and 953
03-01-13	Managed Care Supplement	7	Deleted the Department of Alcohol and Other Drug Abuse from agencies exempt from prior authorizations
02-06-13	3	56	Removed “Present” from Ventilator Dependent, dates

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			of service, April 8, 2011 – September 30, 2011
02-01-13	1	18	Updated URL address for the National Correct Coding Initiative (NCCI)
02-01-13	3	56	Updated administrative days Medicaid rates
01-01-13	3	56	Updated administrative days Medicaid rates
01-01-13	5	1 7 9	• Removed program area contact information • Added Chester county Zip+4 code • Updated Greenville PO Box address
01-01-13	Appendix 1	-	Added Change Log for section changes
12-03-12	1	6 7-8 27-32 33-41	• Updated web addresses for provider information and provider training • Revised heading and language to reflect new provider enrollment requirements • Updated Program Integrity language (entire section) • Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section)
12-03-12	3	10 4,24 38-39	• Updated National Provider Identifier and Medicaid Provider Number • Updated provider information web addresses • Updated Electronic Funds Transfer (EFT)
12-01-12	5	3 11	• Updated web address for provider information • Updated McCormick county office telephone number
12-01-12	Forms	-	Replaced OOS forms
12-01-12	Appendix 1	24, 26, 27, 32, 33 19, 27, 40, 44, 45, 47, 49, 50, 55, 56, 57, 59, 60, 61,	• Updated CARCs for edit codes 538, 552, 555, 561, 562, 563, 636, 637, 690 • Updated resolutions for edit codes 402, 561, 562, 563, 721, 722, 748, 749, 752, 753, 769, 791, 795, 852, 853, 856, 860, 884, 887, 892, 897, 925, 926

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12-01-12	TPL Supplement	8, 9, 17	Updated web addresses for provider information and provider training
11-01-12	5	1	Updated Allendale county office address
11-01-12	Appendix 2	-	Updated carrier code list
10-05-12	Forms	-	Updated Duplicate Remittance Advice Request Form
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card
10-01-12	Appendix 1	-	Updated edit code information through document
08-08-12	2	2	Added note the following revenue codes require a CPT code as of 6/1/12: 420, 424, 430, 434, 440, 444
08-01-12	1	2, 8, 9, 12, 13, 15, 25, 34	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	2	4, 20, 38-40, 50, 52, 56, 62, 70, 71	Updated program area contact information to reflect Medicaid Bulletin dated June 29
08-01-12	3	1 4, 10, 38	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Updated hyperlinks
08-01-12	5	1 5 7	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed fax request information for SCDHHS forms • Added SCDHHS forms online order information • Updated telephone number for Greenville county office
08-01-12	Forms	-	• Deleted forms 140 and 142 • Updated Duplicate Remittance Advice Request Form
08-01-12	Appendix 1	- 1, 24, 60,	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Replaced CARC 141 or CARC A1 for edit codes

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		65, 66-67,70-72 15, 31, 69 8, 10, 29, 31 10, 11, 14, 34, 48	52, 053, 517, 600, 924-926, 929, 954, 961, 964, 966, 967, 969, 980, 985-987 • Added edit codes 349, 590, 978, 990, 991-995 • Deleted edit codes 166, 205, 573, 574, 593, 596 • Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798
08-01-12	Managed Care Supplement	1-2 7 11 17 19	• Changed Division of Care Management to Bureau of Managed Care • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed language limiting enrollment to 2500 members • Update contact information for Palmetto Physician Connections • Added to "Medicaid" to BlueChoice HealthPlan
08-01-12	TPL Supplement	5, 6, 10,17, 24	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
07-01-12	2	9 10-11 11 15 48 49 41	Updated the following sections to reflect new prior authorization policy per Medicaid Bulletin dated May 15. 2012 – Services Performed by KePRO • Pre-Surgical Justification for Elective Hysterectomies • Prior Authorization • Instructions for Obtaining Prior Authorization • Prior Authorization for Inpatient Admissions • Hysterectomy • Retroactive Eligibility • Updated the OOS contact number for Home Health
07-01-12	4	2 19 64-65 69	• Reformatted Reimbursement Type 4 table • Changed table header, column 5 • Deleted outpatient hospital codes 33975-33979, 44135-48556 • Deleted ICD-9 prior authorization code 00.93
07-01-12	Appendix 1	16, 48 45	• Deleted edit codes 386 and 868 • Added edit codes 837, 838, 839

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-12	Appendix 2	-	Updated carrier codes
06-01-12	2	15 8, 50 8-12, 46-48, 53-56 9 23 40 40-41 48 58	• Added Prior Authorization for Inpatient Admissions section • Deleted Hospital Utilization Review and Inpatient Psychiatric Disorders section • Updated the following sections to reflect Medicaid Bulletin dated May 15, 2012 replacing Alliant Health Solutions with Keystone Peer Review Organization, Inc. (KePRO): o Quality Improvement Organization (QIO) o Documentation Requirements o Instructions for Obtaining Prior Authorization o Organ Transplants o Hysterectomy o Back/Spinal Surgery and Other Back Problems o Reconstructive Breast Surgery o Gynecomastia o Obesity • Updated the following sections: o Quality Improvement Organization (QIO) o Outpatient Therapies o Foster Children Residing Out of the SCMSA o Ancillary and Other Out-Of-State Services o Hysterectomy o Kidney Transplants
06-01-12	4	 2 65-70 72-73 77-78 77 48 74-76	Updated the following sections: o Reimbursement Type 4 – Treatment/Therapy/Testing o Outpatient Hospital Surgeries CPT Codes o ICD-9 Authorization Codes o Outpatient Hospital Services (support documentation) o ICD-9 Surgical Codes (support documentation) • Deleted Diagnosis Codes for Acute (Non-State Owned) Inpatient Admissions • Added PT, OT, and Speech Therapy CPT Codes
06-01-12	Forms	-	• Corrected date on Table of Contents for

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Reasonable Effort Documentation form — changed 06/2007 to 05/2007 • Deleted Notice of Noncoverage forms (4) and Hysterectomy Acknowledge (form, instructions and sample) • Replaced DHHS 1723 form with June 2010 version • Updated Notice of Termination of Administrative Days form • Updated the following forms to reflect Medicaid Bulletin dated May 15, 2012 replacing Alliant Health Solutions with Keystone Peer Review Organization, Inc. (KePRO): o Request for Prior Approval Review o Surgical Justification Review for Hysterectomy (form and sample) o Transplant Prior Authorization Request (form and instructions)
05-01-12	Appendix 1	62	Updated edit code 975
04-01-12	1	4	Replaced South Carolina Healthy Connections card
04-01-12	5	11 12	• Updated address for Marion County • Updated phone number for Newberry County
03-01-12	3	1 2 4-6 19 21 37 39 51	• Added Usual and Customary Rates • Added sentence to Claims for Medicare Coinsurance and Deductible • Added sections regarding Web Tool and claim submissions • Updated Medicaid Co-payments • Added Billing Instructions for Service Provided as the result of an Emergency • Added Reimbursement Payment • Updated SCDHHS Area Prefixes • Updated Retro-Medicare
02-07-12	Cover	-	Manual cover updated January 1, 2012
02-07-12	Appendix 1	18 24 30	• Updated edit code 402 • Updated edit code 544 • Updated edit code 636, 637, and 642

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-12	3	35	Updated the Remittance Advice -835 Transaction
02-01-12	5	9	Updated the Fairfield county office number
02-01-12	Appendix 1	18 30 42 49	• Updated edit code 402 • Updated edit code 636, 637, and 642 • Updated edit code 766 • Updated edit code 867
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	2	2 40 48&49 57 6, 73	• Updated Eligibility Requirements • Updated Out-of-State referrals • Updated Organ Transplant information • Updated Adult Dental Services • Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	3	- 35	• Updated hyperlinks throughout section • Updated EFT information
01-01-12	4	19-62 88	Replaced APR-DRGs and Relative Weights table Added code 74174 to High-Tech Radiology Codes
01-01-12	Appendix 1	62 -	• Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11 • Updated CARCs and RARCs throughout the document
01-01-12	Managed Care Supplement	9	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	TPL Supplement	2	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
11-10-11	2	43	Updated Administrative Days per bulletin
11-01-11	1	24	Updated TPL contact information

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-11	2	17 38 72	• Updated cost outlier policy • Added Hospital-Acquired Conditions (HACs) section • Deleted Alcohol and Other Drug Abuse Treatment section
11-01-11	3	10 11 19 21-23, 26 32-33 41-46 47 51	• Updated Discharge/Readmission Within 24 Hours, bullet #3 • Deleted Questionable Admission section • Updated UB-04 manual information • Updated UB-04 fields 15, 17, 67 • Updated Remittance Advice Items N • Updated Payment Calculations for the Hybrid Prospective Payment System (PPS) • Deleted ICD-9 Procedure Code Restrictions table • Under Administrated Days Claims, change changed status in field 17 from “05” to “70”
11-01-11	4	2 19- 81	• Updated fees schedule amounts for 636 w/J1055 – Depo-Provera, 636 w/J7310 – Vitrasert, and 636 w/90378 – Synagis • Replaced Inpatient PPS DRG Relative Weights and DRG Per Diem Rates tables with APR-DRGs and Relative Weights table
11-01-11	TPL Supplement	3, 17, 19	Updated TPL contact information
10-01-11	Appendix 1	14, 29 47	• Added edit codes 334 and 584 • Updated edit code 845
09-09-11	Change Control Record	1	Correction to date 09-01-11, section 4, first bullet: • Page 4-8, revenue code 343 service indicator changed to 4 • Page 4-16, revenue code 924 service indicator changed to 1
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	3	15	Deleted Interim Payment section
09-01-11	4	8, 16	• Changed revenue codes 343 and 924 covered service indicator to 1

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		57	• Added the following codes to the ICD-9 Authorization Codes list: 85.55, 86.87, 86.90
09-01-11	5	13	Updated zip code for Spartanburg County office
09-01-11	Appendix 1	15, 29, 30	Added edit code 361, 591, 596 and 605
08-01-11	2	19 31	• Replaced Partners for Health Medicaid card with South Carolina Healthy Connections card • Updated to reflect Medicaid Bulletin dated May 17, 2011 – Prior Authorization(PA) for High Tech Radiology Services
08-01-11	3	33 -	• Added "H" outpatient copayment descriptor and copayment amount for Remittance Advice, field L • Updated language throughout section to reflect the current billing policies including claim processing, claim submission, and copayments
08-01-11	4	54	Added new High-Tech Radiology codes
08-01-11	Appendix 1	8	Updated edit codes 165 and 166
08-01-11	Appendix 3	1	Updated the copayment schedule per the bulletin effective July 11, 2011
08-01-11	Managed Care Supplement	1, 5	Updated to reflect the new beneficiary copayment requirements in accordance with Public Notice posted July 8, 2011
07-01-11	5	13	Deleted PO Box address for the Spartanburg County Office
07-01-11	Appendix 1	12 43 56	• Updated resolution for edit code 300 • Added edit codes 840 and 841 • Updated Provider Enrollment Contact information in edit codes 941 and 944
07-01-11	Appendix 3	1	Updated the copayment schedule per the bulletin effective July 8, 2011
06-01-11	2	-	Corrected formatting
06-01-11	5	5	Corrected Abbeville County PO Box Zip+4 Code

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	2	2	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	Appendix 1	43	Updated edit code 796
04-01-11	3	20 19, 33	• Changed outpatient hospital copayment to reflect Medicaid Bulletin dated March 16, 2011 – Copayments • Updated Copayment Policy to reflect bulletin dated March 16, 2011
04-01-11	5	6	Updated telephone number for Beaufort County
04-01-11	Forms	-	Updated Electronic Funds Transfer Form
04-01-11	Appendix 3	-	Updated copay amounts to reflect bulletin dated 3-16-11
03-01-11	1	7, 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	2	4	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	3	3, 4, 37	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	5	4 5	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center Added toll free number for Aiken County
03-01-11	Appendix 1	- 67	Added SCDHHS Medicaid Provider Service Center (PSC) information at top of each page in header section Made change to Edit Code 990 description
03-01-11	Appendix 2	-	Updated alpha and numeric carrier code lists to reflect Web site update on 12/14/10
03-01-11	TPL Supplement	17	• Changed the name of the Provider Outreach Web site to Provider Enrollment and Education

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		24, 25	• Updated the descriptions for Form130s
02-01-11	2	19	• Updated to reflect Medicaid Bulletin dated December 14, 2010 – Medicaid Reductions, discontinued covered for routing newborn circumcisions
02-01-11	Appendix 1	3	Added edit codes 079 and 080
01-01-11	1	7 19-20	• Updated the South Carolina Medicaid Web-based Claims Submission Tool section • Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits
01-01-11	2	7	• Removed January 2008 information • Added January 2011 information
01-01-11	3	3, 4, 31, 37 32 23	• Updated electronic remittance package information • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package • Added “Trauma Center” under “14-Admission Types”
01-01-11	5	13	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request Form
01-01-11	Appendix 1	9	Added edit codes 165 and 166
01-01-11	TPL Supplement	8, 10 8 10 13 15 15	• Removed references to Dental claims • Removed language to contact program areas for missing carrier codes • Added reference to CMS-1500 for correcting edit code 151 on the ECF • Added edit code 165 to other TPL-related insurance edit codes list • Updated Retro Medicare section to include the following: o Changed the timely filing requirement from 90 days of the invoice to 30 days o Added SCDHHS TPL recovery language • Updated the Retro Health and Pay & Chase

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			section
12-01-10	Cover	-	Replaced "Medicaid Provider Manual" with "South Carolina Healthy Connections (Medicaid)"
12-01-10	4	2	Updated the prices for J1055 and J7307
12-01-10	Appendices	-	Replaced "South Carolina Medicaid" with "South Carolina Healthy Connections (Medicaid)" in headers
12-01-10	Supplements	-	Replaced "South Carolina Medicaid" with "South Carolina Healthy Connections (Medicaid)" in the headers
11-02-10	4	i	• Updated the Table of Contents to remove references to Qualis Health
11-01-10	2	22 23 24 27 28 29	• Updated Outpatient Services section • Updated A. Outpatient Surgical Services-Reimbursement Type 1 section • Updated B. Outpatient Non-Surgical Services – Reimbursement Type 5 section • Updated C. Treatment/Therapy/Testing (TTT) Services-Reimbursement Type 4 section • Deleted Collection of Blood and Arterial puncture section • Added Clinical Lab Services section • Updated Laboratory Tests, EKGs, and X-rays section
11-01-10	4	1	• Updated Outpatient Fee Schedule-Reimbursement Types; Reimbursement Type 1 and Reimbursement Type 5.
11-01-10	Appendix 1	8 16 32 51 52	• Edit code 202: added information to Resolution section • Edit codes 421 and 424 deleted • Edit code 733 information updated in Resolution section: "Adjust the net charge in field" changed from 26 to 29 • Deleted edit code 959 • Deleted edit codes 962 and 963

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-10	TPL Supplement	3, 8, 13-14, 18-19 6, 15-17	• Updated to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest • Updated to reflect Medicaid Bulletin dated September 13, 2010 – Changes to the Third Party Liability Medicare Recovery Cycle
10-01-10	1	- 1 7 10	• Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Program Description section • Updated the SC Medicaid Web-Based Claims Submission Tool section to reflect Medicaid Bulletin dated July 8, 2010-Transfer of the Dental Program Administration to DentaQuest • Updated Freedom of Choice section
10-01-10	5	11	Correct McCormick county office street address
10-01-10	Managed Care Supplement	- 1 2 3 4 5 6 13 17	• Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Managed Care Overview • Updated Managed Care Organizations and Core Benefits paragraphs • Updated MCO Program ID card paragraph • Updated MHN Program ID card paragraph • Updated Core Benefits • Updated Exempt Services • Updated Overview • Deleted “Medicaid Managed” from “Current Medicaid Managed Care Organizations” heading and following paragraph
09-01-10	2	9-14, 45-54	• Updated the following sections to reflect Medicaid Bulletin dated July 30, 2010 replacing Qualis Health with Alliant Health solutions: o Quality Improvement Organization o Inpatient Psychiatric Disorders o Hysterectomy o Back/Spinal Surgery and Other Back

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		38, 55 43	Procedures o Reconstructive Breast Surgery o Gynecomastia o Gastric Bypass Surgery/Vertical-Branded Gastroplasty • Updated the following sections to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest: o Ancillary and Other Out-of-State Services o Dental Service, Children Under Age 21 • Updated the Administrative Days, Billing Notes section for retroactive eligibility
09-01-10	4	2 47 48, 54	• Added revenue code 404 to Revenue Codes That Require Procedure Codes list • Updated the following sections to reflect Medicaid Bulletin dated July 30, 2010 replacing Qualis Health with Alliant Health solutions: o Diagnosis Code for Acute (Non-State Owned) Inpatient Admissions o Prior Authorization CPT Codes o ICD-9 Prior Authorization Codes
09-01-10	5	2 5 8 11	• Updated Dental Services Medicaid Program contact information • Removed County Commissioner's Building from the Aiken County address • Deleted Dorchester County physical address telephone number • Removed Highway 28 N from the McCormick County address
09-01-10	Forms	-	• Updated all Notice of Non-Coverage forms • Updated the following forms to include the prior approval review fax information: o Request for Prior Approval Review o Surgical Justification Review for Hysterectomy o Surgical Justification Review for Hysterectomy (sample version)
09-01-10	Appendix 1	9	• Added edit code 225

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		-	• Removed all references to the ADA Claim in the Resolution column
09-01-10	TPL Supplement	12 13 18	• Updated the Dental Paper Claims section to delete paper claims submission instructions and added the DentaQuest contact information • Updated the Web-Submitted Claims section with the exception to Dental claims • Updated the TPL Resources section to include the DentaQuest contact information for TPL questions
08-01-10	5	5, 8, 11-13 6	• Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties • Updated the address for Barnwell County • Updated the telephone number for Beaufort County
08-01-10	Forms	-	Corrected formatting on the Community Long-Term Care Notification Form
08-01-10	Appendix 1	20 51, 52 59	• Deleted edit code 520 • Deleted Provider Enrollment e-mail address from codes 941 and 944 • Changed resolution for edit code 994
07-01-10	3	38	Changed First Health to Magellan Medicaid Administration
07-01-10	4	4 53	Added revenue code 404 Deleted CPT code 58565
07-01-10	5	-	Updated telephone numbers and zip codes for multiple county offices
07-01-10	Forms	-	Updated the following forms: • Consent for Sterilization • Request for Prior Approval Review • Surgical Justification Review for Hysterectomy
07-01-10	Appendix 1	32 35	• Updated edit code 714 • Updated edit code 738
07-01-10	Appendix 2	21, 22, 25,	Changed First Health to Magellan Medicaid

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		63, 89	Administration
06-01-10	Managed Care Supplement	1 3 17 20, 23, 25	• Updated Managed Care Overview section • Updated Manage Care Organization (MCO), Core Benefits section • Updated the Managed Care Disenrollment Process, Overview section • Updated to reflect Medicaid Bulletin dated March 18, 2010 — Managed Care Organizational Change
03-01-10	Cover	-	Replaced the manual cover
03-01-10	Change Control Record	1	Added Time Limit for Submitting Claims Medicaid Bulletin date to section 1 and section 3 entries dated 12-01-09
03-01-10	3	1, 3 23	• Removed modem as an electronic claims transmission method • Under field 17 Patient Status as follows: o Status 01 and 04 – Added usage note o Status 05 – Replaced status name o Status 08 – Deleted o Status 21 – Added usage note
03-01-10	4	53	Added new codes 63661, 63662, 63663, 63664
02-01-10	Appendix 1	13 36	• Added New Edit Codes 356,357 and 358 • Updated Edit Code 738
02-01-10	Appendix 2	All	Updated Carrier Code List
01-01-10	2	7 8	• Updated the Medicare/Medicaid (Dually Eligible) section to reflect the Medicaid allowable amounts effective January 2010 • Deleted the 2007 Medicaid allowable amounts
01-01-10	4	2 58	• Changed the price for revenue code 636 w/J7307 – Implanon • Changed the ICD-9 Codes Support Documentation heading to ICD-9 Surgical Codes Requiring Support Documentation and included “surgical” in the text description

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			• Added new ICD-9 Diagnosis Codes Requiring Support Documentation section
01-01-10	5	5 10 12	• Updated Physical Address for Allendale County Office • Replaced Jasper County DSS with Jasper County DHHS • Replaced Orangeburg County DSS with Orangeburg County DHHS
01-01-10	Appendix 1	49	Updated Edit Code 932
12-01-09	1	8 25	• Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package • Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009
12-01-09	3	1-2 17-25	• Updated Claim Filing Timeliness section to reflect Medicaid Bulletin dated November 24, 2009 • Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package
12-01-09	5	8	Updated the Dorchester County office street address
12-01-09	Appendix 1	- - 18, 19 20	• Replaced CARC 17 with CARC 16 • Updated CARC A1 • Updated codes 509 and 510 • Added code 533
11-01-09	2	i-v	Reformat Table of Contents
11-01-09	4	2	Updated pricing for revenue code 636 w/90378 Synagis®
11-01-09	Appendix 2	All	Updated carrier code list
10-01-09	1	3-4 4-6	• Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs) • Updated SC Medicaid Healthy Connections

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		26	language throughout section • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing
10-01-09	2	71	Added Qualified Medicare Beneficiary subsection
10-01-09	3	35 57	• Reformatted link • Updated the reimbursement rate table
10-01-09	4	47-52 50 52	• Changed the document headers and renumbered charts • Removed code 15847 • Removed duplicate code 58294
10-01-09	5	10 11 12	• Updated physical address for Jasper County office • Updated telephone number for Lexington County office • Updated zip codes for Orangeburg County office
10-01-09	Appendix 1	3 60	• Updated edit code 065 • Updated edit code 852
09-08-09	Managed Care Supplement	20	Replaced the Absolute Total Care Medicaid beneficiary card sample
09-01-09	Managed Care Supplement	21 20, 25	• Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009 • Updated Absolute Total Care entries as following: o Changed the company's name to Absolute Total Care o Replaced the beneficiary card samples o Corrected contact information
08-01-09	2	12 54	• Updated the Retrospective Reviews subsection • Updated the Reconstructive Breast Surgery subsection
08-01-09	4	2 12	• Changed the following codes in the Revenue Codes That Do Not Require Procedure Codes column with Fee Schedule Amounts column: J1055, J7307, J7310 • Added code 614 to the Revenue Codes That

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		41, 43, 45 57	Require Procedure Codes column • Added code 614 to Revenue Code table • Corrected header • Changed code 85.60 to 85.6 in the Qualis Health ICD-9 Prior Authorization Codes table
08-01-09	5	14	Updated telephone number for York County office
08-01-09	Appendix 1	3	Updated edit code 062
08-01-09	Appendix 2	-	Updated carrier code list
07-01-09	2	48	Added new Inpatient Psychiatric Disorders subsection
07-01-09	4	47-48	Added new chart for acute(non-state owned) procedure codes
07-01-09	5	6, 12 8 9	• Updated address for Bamberg and Orangeburg County offices • Updated office zip code for Darlington County • Updated telephone number for Fairfield County office
06-01-09	3	3	Removed all-inclusive rate under the EMTALA (Emergency Medical Treatment and Labor Act) subsection
06-01-09	4	1	Updated the Reimbursement Type 5 – Non-Surgical subsection
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address
05-01-09	1	1-6, 11 2 3 5 28-33	• Updated to reflect managed care policies and procedures effective May 1, 2009 • Updated the Eligibility subsection • Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection • Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection • Updated the Medicaid Program Integrity subsection

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-09	2	5, 13, 71-72	Updated to reflect managed care policies and procedures effective May 1, 2009
05-01-09	3	57	Updated the administrative days reimbursement rates
05-01-09	5	2 14	• Updated telephone number for Managed Care Services • Updated telephone number for Union County office
05-01-09	Appendix 1	43	Deleted edit code 694
05-01-09	Appendix 2	-	Updated list of carrier codes
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009
04-01-09	1	2, 3, 8	Updated hyperlinks
04-01-09	2	47 57	• Updated Organ Transplant, Group II subsection • Restored Dental Services policy to reflect Medicaid Bulletin dated March 4, 2009
04-01-09	3	3, 7, 35 40-51	• Updated hyperlinks • Updated payment Calculations For The Hybrid Prospective Payment System (PPS) subsection
04-01-09	4	39-48 54	• Updated the DRG Per Diem Rates • Add code 03.09 to the Qualis Health ICD-9 Prior Authorization Codes list
04-01-09	5	11	Updated telephone number for Lexington County office
04-01-09	Forms	-	Add Transplant Prior Authorization forms and instructions
03-01-09	2	24	Updated hyperlink
03-01-09	5	3 8 5, 11-13	• Updated hyperlink • Corrected Dorchester County's Orangeburg Road telephone number • Change DSS to DHHS in addresses for Abbeville,

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			McCormick, Newberry, and Saluda counties
03-01-09	Appendix 1	43 72	• Added new edit codes 693 and 694 • Changed edit code 945 Resolution to input "26"modifier in field 18
03-01-09	Managed Care Supplement	1, 7, 10, 17, 23, 25-30, 35	Updated hyperlinks
03-01-09	TPL Supplement	8, 9, 19	Updated hyperlinks
02-01-09	2	12, 54, 57	Updated policy to reflect Medicaid Bulletin dated January 15, 2009
02-01-09	4	47-55	Updated codes to reflect Medicaid Bulletin dated January 15, 2009
02-01-09	5	5	Updated Allendale County office PO Box zip code
02-01-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form
02-01-09	Appendix 2	-	Updated list of carrier codes
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	2	7	• Removed "As of January 2006" from manual • Updated deductible and coinsurance information for 2009
01-01-09	5	11	Updated Lee County office address
12-01-08	4	9	Revised code 404 Covered Service to 4
11-01-08	1	8	Added e-bulletin information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	2	72-77	Changed MHLN to Medical Homes Network (MHN)
11-01-08	3	29, 34	Added EFT information to reflect Medicaid Bulletin dated August 26, 2008

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
11-01-08	4	1, 2 2 49, 50, 52, 53 47, 48, 49, 51, 52	• Revised verbiage in Reimbursement Type 1, 4 and 5 sections and in Outpatient Fee Schedule: Reimbursement Types. • Changed amount for Synagis to $845.11 • Added and deleted various ICD-9 codes • Added and deleted various CPT codes
10-01-08	5	9, 13	• Updated address for Lake City • Updated phone number for Sumter County office
10-01-08	Forms	-	Updated sample ECF
10-01-08	Appendix 1	-	Updated edit codes 007, 059, 112, 219, 308, 339, 386, 403, 710, 722, 786, 798, 799, 843, 844, 845, 912, 914, 928, 941, 942, 943, 945, 952
09-01-08	2	25	Removed Implanon information.
09-01-08	4	1 48	• Removed Implanon information from Outpatient Fee Schedule. • Added four codes to the Codes Requiring Prior Authorization and Support Documentation section.
09-01-08	5	6	Updated phone number for Berkeley County office
09-01-08	5	10	Updated phone number for Kershaw County office
09-01-08	Appendix 1	17	Added Edit Code 318
08-01-08	2	13 48 54-55	• Updated Support Documentation Information • Updated Hysterectomy Information • Updated Reduction in Mammaplasty and Gynecomastia Information
08-01-08	5	7	Deleted PO Box for Chester County
08-01-08	Appendix 1	3	Updated Edit Code 062
07-01-08	3	55	Changed the flowing sentence from Claims should be billed monthly (calendar month) and are paid a per diem rate to Claims must be billed monthly (calendar

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			month) and are paid a per diem rate.
07-01-08	4	2	Added an asterisk to Revenue Code 410
07-01-08	5	11	Deleted PO Box for Lancaster County
07-01-08	Managed Care Supplement	27	Replaced Web site address for BlueChoice
06-01-08	3	7, 23, 24, 27, 29, 57 8, 9	• Updated NPI policy and form instructions to reflect May 23, 2008, deadline requiring NPI only on claims for typical providers, including deleting field 51 • Added new NDC requirement
06-01-08	5	12	Updated telephone number for Orangeburg county office
06-01-08	Forms	-	Updated the following forms to reflect May 23, 2008, deadline requiring NPI only: • Sample Remittance Advice • Request for Prior Approval Review • Surgical Justification Review for Hysterectomy • Surgical Justification Review for Hysterectomy Sample
06-01-08	Appendix 1	30, 39, 42	• Added new edit code 0529 • Deleted NPI warning edits 578, 579, 580, 581, 582, 583, 692
06-01-08	TPL Supplement	-	Updated Example Dental Claim Form Reporting Third-Party for Medicare Information to show NPI only; change/removed sample entries for fields 8, 15, 23, and 49; and added a tooth number to line 4
05-01-08	Appendix 1	3, 38 31	• Revised edit codes 062 and 569 • Added edit code 520
05-01-08	Managed Care Supplement	-	Revised supplement to include general policies and procedures effective May 1, 2008 and updated the SCDHHS-approved MCO contractors section
04-01-08	2	3	• Added information on location of supervising

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		67-70 25-31	entities • Updated Family Planning Waiver section • Updated injection code for Implanon
04-01-08	3	8, 26 27	• Added information on POA indicator • Updated injection code for Implanon
04-01-08	4	55-56 56-58 1-2, 55	• Updated Family Planning procedure and diagnosis codes • Added STI diagnosis and drug lists • Updated injection code for Implanon
04-01-08	5	8	Updated address and phone number for Dorchester County office
04-01-08	Appendix 1	4, 13, 20, 33	Added new edit codes 062, 291, 339, 528
04-01-08	TPL Supplement	2 3, 8, 15 12 29	• Updated reference to Medicaid card name • Changed references to location of forms from Section 5 to Forms section • Updated field numbers for occurrence codes on UB-04 • Replaced sample ADA form with more attractive version
03-01-08	1	3-5 7	• Replaced sample Partners for Health Medicaid card with new Healthy Connections card and updated card information • Deleted information about location of supervising entities – requirements will be included in Section 2 where applicable
03-01-08	3	7-8 All	• Updated NPI policy and form instructions to reflect March 1, 2008, deadline requiring NPI on claims for typical providers (with or without Medicaid legacy number). • Standardized formatting
03-01-08	Forms	-	Replaced Form 931 with new version dated January 2008
03-01-08	Appendix 1	59 70	• Added edit code 808 • Revised edit code 943 description and status

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			(from warning to active)
03-01-08	TPL Supplement	9 21-22	• Added information on carrier code "CAS" for open casualty cases • Replaced Form 931 samples with new versions
02-01-08	4	40-46	Corrected Section heading
02-01-08	5	1	Removed "including Partners for Health" from first paragraph
02-01-08	Forms	-	Corrected mailing address for Medicaid Refunds Form 205
01-01-08	2	7	Updated deductible and coinsurance information
01-01-08	3	55	Updated Administrative Days rates
01-01-08	4	2	Updated Outpatient Fee Schedule
01-01-08	5	10	Updated address for Lancaster County office
01-01-08	Managed Care Supplement	1 3	• Removed PhyTrust from the list of MHNs • Added Carolina Crescent to the list of MCOs
12-01-07	4	19	Corrected effective date of DRG schedule
12-01-07	5	8, 10, 12	• Updated addresses for Edgefield, Lancaster and Oconee County offices • Updated zip code for Kershaw County
11-01-07	2	24	Removed Newborn Hearing Screening Information
11-01-07	3	39-48	Updated reimbursement payment calculations to October 1, 2007 versions
11-01-07	4	1-2 19-38 39-46	• Replaced outpatient fee schedule with updated version • Replaced DRG listing with updated version • Added new DRG per diem rates
11-01-07	5	9, 10	• Updated telephone numbers for Florence and Kershaw counties

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		10	• Updated Horry County address to 1601 11th Ave., 1st Floor
11-01-07	Forms	-	Replaced old Sterilization Consent Form with new version
11-01-07	Appendix 1	All	• Corrected ECF field numbers throughout edit resolution instructions • Added new edit code 107
11-01-07	Appendix 2	All	Updated list of carrier codes
10-01-07	1	1-2 3 4 12 15 25	• Removed PEP information • Added information about managed care enrollment broker and Managed Care Supplement • Removed managed care sample cards (cards and other information will appear in the new Managed Care Supplement). • Clarified that "days" refers to business days • Clarified which sections of manual may contain PA information • Expanded provider list under Program Integrity
10-01-07	2	24-26, 30-31 46-48 58 71-76	• Added information about newborn hearing screenings and Implanon™ • Updated organ transplantation information • Added PET scan guidelines • Removed PEP information from Managed Care section
10-01-07	3	4 10 26, 36, 38	• Added 90-day time limit from reversing refunds • Added new section on Questionable Admission • Removed PEP information
10-01-07	Appendix 1	26 38-40, 43, 70	• Corrected description for edit code 502 • Added NPI warning edits 578-583, 692, 943
10-01-07	-	-	Added Managed Care Supplement
10-01-07	TPL Supplement	15-17	• Added 90-day time limit for reversing refunds • Added information on Part B timely filing schedule to explain which claims are pulled into

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Retro Medicare
07-01-07	1	All	Revised policies and procedures throughout section
07-01-07	2	-	• Updated QIO information for Qualis Health • Added Family Planning services section • Updated Family Planning Waiver information
07-01-07	3	-	• Updated form instructions for UB-04 • Added NPI information
07-01-07	4	-	• Add Family Planning Waiver codes • Updated lists of codes requiring support documentation and prior authorization
07-01-07	5	-	• Split forms and exhibits to create new Forms section • Updated sources for UB-04
07-01-07	Forms	-	• Updated DHHS forms to add National Provider Identifier field and change CCME to Qualis Health • Insert new blank UB-04 • Updated ECF and remits to new versions • Updated DHHS Form 218
07-01-07	Appendix 2	-	Updated list of carrier codes
06-01-07	Appendix 1	-	Updated list of edit codes
06-01-07	TPL Supplement	All	• Updated all sample forms and claims with new versions • Updated form completion instructions to match new form versions
05-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	5	8	Updated phone number for Darlington county office
04-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	Appendix 2	-	Updated list of carrier codes
03-01-07	2	79	Removed Healthy Options Program section

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-07	3	54	Changed Administrative days rate to $136.99
03-01-07	5	6	Updated Barnwell county office address
03-01-07	Appendix 1	-	Updated list of edit codes
02-01-07	TPL Supplement	31-32	Updated ECF Samples to show third payer line
01-01-07	2	7	Updated deductible and coinsurance information
01-01-07	2	7	Removed “as of January 2004” from manual
01-01-07	3	53	Changed Medicaid rate for administrative days and sub-acute
01-01-07	4	2	Corrected procedure code chart
01-01-07	Appendix 1	9, 14	Added Edit Codes 202, 203, 204, 301
01-01-07	Appendix 2	-	Updated list of carrier codes
12-01-06	2	7	Updated deductible and coinsurance information
12-01-06	2	37	Removed bullet under “Treatment Rendered Outside the SC Medical Area”
12-01-06	3	13	Added verbiage in Medicare/Medicaid Dual Eligibility section
12-01-06	3	13, 14	Updated Medicare Part A Billing section
12-01-06	4	1	Changed website to www.scdhhs.gov under Outpatient Fee Schedule, Reimbursement types 1 and 5
12-01-06	4	2, 12	Updated list of revenue codes
12-01-06	4	19	Updated DRG list
11-01-06	5	-	Updated county office addresses
10-01-06	5	-	Updated county office addresses

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-06	Appendix 2	-	Updated list of carrier codes
09-01-06	5	-	Updated county office addresses
09-01-06	Appendix 1	10,11,13 15,17,18 22, 23, 24 26, 27, 28 29 ,30 ,31 32, 35, 36 39, 40, 41 42, 46, 47 48, 49, 50 52, 58, 60 61, 62, 63 66 ,67	• Updated CARCs for edit codes 504, 561, 562, 563, 636, 923, 940, 949 • Updated RARCs for edit codes 207, 208, 227, 234, 239, 263, 317, 369, 377, 421, 501, 504, 505, 507, 508, 515, 541, 545, 553, 564, 570, 672, 674, 709, 714, 719, 721, 722, 748, 749 • Updated resolutions for edit codes 761, 764, 765 768, 769, 771, 772, 773, 774 • Added new edit codes 518, 724 • Deleted edit code 777
08-01-06	-	-	Added TPL Supplement
08-01-06	5	-	Updated Reasonable Effort Documentation form
07-01-06	Appendix 1	23, 60, 61	Updated resolution for edit codes 504, 923, 940
07-01-06	Appendix 2	-	Updated list of carrier codes
07-01-06	4	39-42	Updated procedure codes to reflect 2006 CPT updates
05-01-06	Appendix 1	52	Updated resolution for edit code 852
05-01-06	3	All	Changed all occurrences of “item” to “field” in reference to UB-92 claim form
04-01-06	Appendix 1	43	Updated resolution for edit code 735
04-01-06	Appendix 2	-	Updated list of carrier codes
04-01-06	2, 3	-	Updated deductible, coinsurance, and blood deductible information and other policies in accordance with Medicaid Bulletins dated February 6 and March 7, 2006.
04-01-06	4	19-39	Updated DRG list
03-01-06	Appendix 1	60	Changed resolution for edit code 925

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-06	Appendix 1	41	Changed resolution for edit code 721
01-01-06	2, 4, 5	-	Changed "Carolina Medical Review" to "The Carolinas Center for Medical Excellence" throughout manual; updated CCME address, phone, and fax number.
01-01-06	5	21	Updated Authorization Agreement for Electronic Funds Transfer
01-01-06	5	44, 45	Removed Form 204 – Pregnancy/Newborn Risk Assessment – from manual
01-01-06	5	27	Updated ESRD Enrollment Form
01-01-06	1	4, 5	Removed SILVERxCARD sample and program description
01-01-06	Appendix 2	-	Updated list of carrier codes
01-01-06	Appendix 1	67	Added edit code 935
12-01-05	Appendix 1	70	Added edit code 949
11-01-05	1	6, 7	Removed "HIPAA" from names of S.C. Medicaid Provider Outreach and S.C. Medicaid EDI Support Center
11-01-05	3	5, 7	Changed verb tense under Procedural Coding and Diagnostic Codes
11-01-05	3	3	Changed generic reference for the South Carolina Medicaid Web-based Claims Submission Tool from SCMWBCST to Web Tool
11-01-05	3	3	Changed Web site from www.scdhhshipaa.org to www.scmedicaidprovider.org
11-01-05	5	5-14	Updated list of DHHS county offices
10-01-05	5	5-14	Updated list of DHHS county offices
10-01-05	Appendices	-	Made each appendix a separate file; moved Change Control Record out of appendices to a separate file

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-05	4	5, 8	Corrected revenue code descriptions
10-01-05	3	3 23-38	• Removed references to PAID system • Made small corrections to revenue coding and reimbursement types
10-01-05	2	15, 18, 21 24, 27, 55 56, 57, 70 75	• Corrected minor errors, clarified inpatient/ outpatient distinction • Added section on Collection of Blood and Arterial Puncture
09-01-05	Appendix 2	All	Updated lists of carrier codes
09-01-05	Appendix 1	38, 64	Added edit codes 577 and 900
08-01-05	Appendix 1	62	Added edit code 868
07-01-05	Appendix 2	All	Updated lists of carrier codes.

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

TABLE OF CONTENTS

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

TABLE OF CONTENTS

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

TABLE OF CONTENTS

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, provides quality health care to low income, disabled, and elderly individuals by utilizing state and federal funds to reimburse providers for approved medical services. This care includes the diagnosis, treatment, and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.

SCDHHS offers a fully capitated Managed Care Program through Managed Care Organizations. A Primary Care Case Management/Medical Home Network model is only available for participants that qualify for the Medically Complex Children's Waiver. For more information regarding this care model, please see the Managed Care Supplement included with this manual.

The Medicaid Managed Care Organization (MCO) program consists of contracted MCOs that, through a developed network of providers, provide, at a minimum, all services outlined in the core benefit package described in the MCO contract and MCO Policies and Procedure guide, for certain eligibility categories. SCDHHS pays MCOs a per member per month capitated rate, primarily according to age, gender, and category of eligibility. Payments for core services provided to MCO members are the responsibility of MCOs, not the Fee-for-Service Medicaid program.

MCOs may elect to provide their members enhanced services beyond what is offered under traditional fee-for-service Medicaid.

ELIGIBILITY DETERMINATION

Applications for Medicaid eligibility may be submitted online at apply.scdhhs.gov. The application is also

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ELIGIBILITY DETERMINATION (CONT'D.)

available for download on the SCDHHS website at http://www.scdhhs.gov and can be returned by mail, fax, or in person. Individuals can continue to apply for Medicaid at out-stationed locations such as county health departments, some federally qualified health centers, most hospitals, and SCDHHS county eligibility offices.

Individuals who apply for SSI through the Social Security Administration and are determined eligible are automatically eligible for Medicaid.

For certain programs, Medicaid eligibility may be retroactive for a maximum of three months prior to the month of application when the applicant received medical services of the type covered by Medicaid and the applicant would have met all eligibility criteria had the application been filed at the time. A child born to a woman eligible for Medicaid due to pregnancy is automatically entitled to Medicaid benefits for one year provided that the child continues to reside in South Carolina.

Not all Medicaid beneficiaries receive full coverage. Some beneficiaries may qualify under the categories of limited benefits or emergency services only. Questions regarding coverage for these categories should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us. A provider service representative will then respond to you directly with additional information about these categories.

Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing the South Carolina Medicaid Web-based Claims Submission Tool or an eligibility verification vendor. Additional information on these options is detailed later in this section.

Certain services will require prior approval and/or coordination through the managed care provider. For questions regarding the Managed Care program, please visit the SCDHHS website at http://scdhhs.gov to view the MCO Policy and Procedure Guide.

More information about managed care can also be found in the Managed Care Supplement included with all provider manuals.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ENROLLMENT COUNSELING SERVICES

SCDHHS provides enrollment counseling services to Medicaid beneficiaries through a contract with a private vendor. Services are provided under the program name "South Carolina Healthy Connections Choices." The function of the enrollment counselor is to assist Medicaid-eligible members in the selection of the best Medicaid health plan to suit individual/family needs. For additional information, visit http://www.SCchoices.com or contact South Carolina Healthy Connections Choices at (877) 552-4642.

MEDICARE / MEDICAID ELIGIBILITY

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers may bill SC Medicaid for Medicare cost sharing for Medicaid-covered services for dually eligible beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible beneficiary is also a QMB, providers may bill SC Medicaid for Medicare cost sharing, for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. For instructions on how to access beneficiary information, including QMB status, refer to the Medicaid Web-Based Claims Submission Tool (the Web Tool), explained later in this section.

In the Web Tool, the Eligibility or Beneficiary Information section will indicate "Yes" if the beneficiary is a Qualified Medicare Beneficiary.

Note: Pharmacy providers should refer to Section 2 of the Pharmacy Services Provider Manual for more information on coverage for dually eligible beneficiaries.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

Medicaid beneficiaries are issued a plastic South Carolina Healthy Connections Medicaid card. Only one person's name appears on each card. If more than one family member is eligible for Medicaid, the family receives a card for each eligible member. In addition to the member's name, the front of the card includes the member's date of birth and Medicaid Member Number. Possession of the plastic card does not guarantee Medicaid coverage. Failure to verify eligibility prior to providing a service leaves the provider at risk of providing services to an ineligible individual.

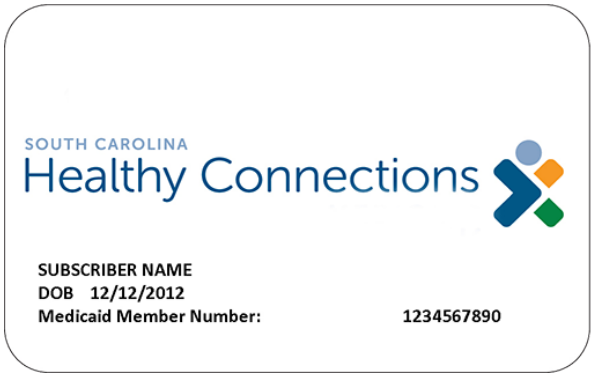
As of August 1, 2016, SCDHHS announced the release of a new South Carolina Healthy Connections Medicaid card. The new card will no longer contain a magnetic data strip. The new cards will be issued to newly enrolled beneficiaries and current beneficiaries who request replacement cards. All active beneficiaries prior to August 1, 2016, will continue to use their current Medicaid card until further notice.

Providers shall accept all versions of the existing cards: cards with a magnetic data strip and the blue Healthy Connections Checkup card. All providers are encouraged to use the Web Tool to check eligibility. For additional information about the Web Tool, please refer to South Carolina Medicaid Web-Based Claims Submissions Tool (Web Tool) later in this section.

The following are examples of valid South Carolina Healthy Connections Medicaid cards:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM



The back of the Healthy Connections Medicaid card includes:

- A toll-free number for providers to contact the PSC for assistance
- A toll-free number for the beneficiary if he or she has questions about enrollment or Medicaid-covered services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD (CONT'D.)

- A toll-free number for the beneficiary if he or she has questions regarding pharmacy services

Providers are urged to report inappropriate use of a Medicaid card by a beneficiary (such as abuse, card-sharing, etc.) to the Division of Program Integrity's toll-free Fraud and Abuse Hotline at 1-888-364-3224.

Beneficiaries who are enrolled with a MCO will also be issued an identification card by the MCO. This MCO-issued card contains phone numbers for member services and provider billing issues specific to the managed care plan. Please see the Managed Care Supplement for samples of cards from the various managed care plans.

SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL (WEB TOOL)

SCDHHS provides a free tool, accessible through an Internet browser, which allows providers to submit claims (UB and CMS-1500), attach supporting documentation, query Medicaid eligibility, check claim status, offers providers electronic access to their remittance advice, and the ability to change their own passwords.

Providers interested in using this tool must complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS and return the signed SC Medicaid TPA Enrollment Form. Once received, the provider will be contacted with the website address and Web Tool User ID(s). If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file. The provider's TPA must name their billing agent. The billing agent's TPA must include the provider's name and Medicaid number. For more information regarding the TPA, refer to Section 3 of this manual.

To learn more about this tool and how to access it, visit the SC Medicaid Provider Education website at: http://medicaidelearning.com/ or contact the SC Medicaid EDI Support Center via the SCDHHS PSC at 1-888-289-0709. A listing of training opportunities is also located on the website.

Note: Dental claims cannot be submitted on the Web Tool. Please contact the dental services vendor at 1-888-307-6553 for billing instructions.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA MEDICAID ALERTS, BULLETINS AND NEWSLETTERS

SCDHHS Medicaid alerts, bulletins and newsletters are distributed electronically through e-mail and are available online at the SCDHHS website.

To ensure that you receive important SC Medicaid information, visit the website at http://www.scdhhs.gov/ and subscribe to alerts, bulletins and newsletters.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION

The Medicaid program administered by the South Carolina Department of Health and Human Services (SCDHHS) is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Provider participation in the Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet the following requirements:

- Complete an online provider enrollment application and agreement and submit any necessary supporting documentation. Certain provider types, depending on the type of service provided, are required to sign a contractual agreement in addition to the provider enrollment agreement.
- Accept the terms and conditions of the online application by electronic signature, indicating the provider's agreement to the contents of the participation agreement, the Electronic Funds Transfer Agreement, W-9 and Trading Partner Agreement.
- Be licensed by the appropriate licensing body, certified by the standard-setting agency, and/or other pre-contractual approval processes established by SCDHHS.
- If eligible, obtain a National Provider Identifier (NPI) and share it with SCDHHS. Refer to https:// nppes.cms.hhs.gov for additional information about obtaining an NPI.
- Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment. This also applies to providers wanting to contract with one or all of the South Carolina Medicaid MCO.
- Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION (CONT'D.)

- Comply with all federal and state laws and regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program.
- Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

All rendering providers must be enrolled in the Medicaid program. Enrolled providers are prohibited from allowing non-enrolled providers use of their Medicaid ID number/NPI number in order for non-participating providers to be reimbursed for services. Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the ordering, referring or rendering provider will be considered invalid and may result in a program integrity investigation and/or recoupment of the Medicaid payment. As required by 42 CFR 455.440, all claims submitted for payment for items and services that were ordered or referred must contain the NPI of the physician or other professional who ordered or referred such items or services.

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to SCDHHS PSC within 30 days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Provider Enrollment inquiries to South Carolina Medicaid should be directed as follows:

Mail: Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
Phone: 1-888-289-0709, Option 4
Fax: 803-870-9022

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render. A provider may not refuse to furnish services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

Extent of Provider Participation (Cont'd.)

covered under Medicaid to an eligible individual because of a third party's potential liability for the service(s). A provider who is not a part of a MCO's network may refuse service to a Medicaid MCO member.

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid-eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly with the MCO.

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment. The policy section of this manual may include clarification of specific program policies.

Non-Discrimination

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

Non-Discrimination (Cont'd.)

- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)

Service Delivery

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid beneficiary has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the beneficiary as a patient.

However, once a beneficiary exercises his or her freedom of choice by enrolling in a Medicaid MCO, the beneficiary is required to follow that MCO's requirements (*e.g.*, use of designated primary and specialist providers, precertification of services, etc.) for the time period during which the beneficiary is enrolled in the MCO.

Medical Necessity

Medicaid will pay for a service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records or other appropriate documentation for each beneficiary must substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide immediate access to original and electronic medical records, including associated audit trails. Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record.

SCDHHS does not have requirements for the media formats for medical records. Providers must have and maintain a medical record system that insures that the record may be accessed and retrieved immediately. That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment to SCDHHS, the State Auditor's Office (SAO), the South Carolina Attorney General's Office (SCAG), the United States Department of Health and Human Services (HHS), Government Accountability Office (GAO), and/or their designee during normal business hours.

SCDHHS will accept electronic records and clinical notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §§ 26-6-10 et seq.) and the Health Insurance Portability and Accountability Act (HIPAA) electronic health record requirements. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

A provider is defined as an individual, firm, corporation, association or institution which is providing, or has been approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act of 1932, as amended.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION (CONT'D.)

Records are considered to be maintained when:

- They fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries
- All required documentation is present in beneficiaries' records before the provider files claims for reimbursement, unless program policy otherwise states
- Beneficiary medical, fiscal and other required records and supporting documentation must be legible

A provider record or any part thereof will be considered illegible if at least three (3) medical or other professionals in any combination, who regularly perform post payment reviews, are unable to read the record or determine the extent of services provided. An illegible record will be subject to recoupment.

Medicaid providers must make records immediately accessible and available for review during a provider's normal business hours or as otherwise directed, with or without advance notice by authorized entities and staff as described in this section. An authorized entity may either copy, accept a copy, or may request original records. Any requested record(s) is deemed inaccessible if not immediately available when requested by an authorized entity. Unless otherwise indicated, the medical record shall be accessible at the provider's service address as documented by the SCDHHS provider enrollment record. If the requested records are not available, they must be made available within two (2) hours of the authorized entity's request, or are otherwise deemed inaccessible. It is the responsibility of the provider to transport/send records to the place of service location as documented by the SCDHHS provider enrollment record.

The following requirements apply to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. That for Medicaid purposes all fiscal and medical records shall be retained for a minimum period of five (5) years after last payment was made for services rendered, except that hospitals and nursing homes are required to retain such records for six (6) years after last payment was made for services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

General Information (Cont'd.)

rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the appropriate retention period the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the appropriate retention period, whichever is later.

Providers may contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for specific information regarding documentation requirements for services provided.

Signature Policy

For medical review purposes, Medicaid requires that services provided/ordered be authenticated by the author. Medical documentation must be signed by the author of the documentation except when otherwise specified within this policy. The signature may be handwritten, electronic, or digital. Stamped signatures are unacceptable.

Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, SCDHHS shall consider evidence in a signature log to determine the identity of the author of a medical record entry.
- An order must have a signature which meets the signature requirements outlined in this section. Failure to satisfy these signature requirements will result in denial of related claims.
- A stamped signature is unacceptable.

Signature Log

Providers may include a signature log in the documentation they submit. This log lists the typed or printed name of the author associated with the illegible initials or signature.

Electronic Signatures

Providers using electronic signatures need to realize that there is a potential for misuse with alternative signature methods. The system needs to have software products that are protected against modification and that apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider are responsible for the authenticity of the information for which an attestation has been provided.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

Electronic Signatures (Cont'd.)

Acceptable Electronic Signature Examples:

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D'
- 'Authorized by: John Smith, M.D'
- 'Digital Signature: John Smith, M.D'
- 'Confirmed by' with provider's name
- 'Closed by' with provider's name
- 'Finalized by' with provider's name
- 'Electronically approved by' with provider's name
- 'Signature Derived from Controlled Access Password'

Date

The signature should be dated. However, for review purposes, if there is sufficient documentation for SCDHHS to determine the date on which the service was performed/ordered then SCDHHS may accept the signature without a date.

The only time it is acceptable for an entry to not be signed at the time of the entry is in the case of medical transcription.

Exceptions

There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub. 100-02, chapter 15, section 80.6.1,

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

Exceptions (Cont'd.)

state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (*e.g.,* a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

DISCLOSURE OF INFORMATION BY PROVIDER

As of April 14, 2003, for most covered entities, health care providers are required to comply with privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, which includes providing all patients and/or clients with a Notice of Privacy Practices. The Notice should include sufficient information to disclose to each Medicaid patient/client the provider's intent to release any medical information necessary for processing claims, including Medicaid claims. Providers who have not issued their patients/clients a Notice of Privacy Practices should obtain authorization to release such information to SCDHHS. The authorization must be signed and dated by the beneficiary and must be maintained in the patient's/client's record.

Once a Notice of Privacy Practices is acknowledged by the Medicaid beneficiary, or the beneficiary's authorization to release information is obtained, a provider who uses hard-copy claim forms that require the patient's signature is no longer required to have each claim form signed by the beneficiary. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the beneficiary consenting to the release of information necessary to process claims.

Certain medical services may be subject to more stringent rules or regulations governing the disclosure of information than others. However, if a provider is unable to release information necessary for Medicaid claims processing due to the lack of proper Notice or authorization from the beneficiary, payment may be denied and/or previous payments may be recouped. Consequently, providers who are concerned about releasing patient information to SCDHHS are advised to obtain specific written authorization from the Medicaid patient/client.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION

Federal regulations at 42 CFR Part 431, Subpart F, and South Carolina Regulations at Chapter 126, Article 1, Subarticle 4, require that certain information concerning Medicaid applicants and beneficiaries be protected. As a condition of participation in the Medicaid program, all providers must agree to comply with the federal laws and regulations regarding this protection, by execution of either a contract or a provider enrollment agreement. Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at http://scdhhs.gov/contact-us to request additional information.

Beneficiary information that must be protected includes but is not limited to the following:

- Name and address
- Medical services provided
- Social and economic circumstances
- Medical data, including diagnosis and past history of disease or disability
- Any information involving the identification of legally liable third-party resources
- Any information verifying income eligibility and the amount of medical assistance payments

This information may generally be used or disclosed only for the following purposes:

- Establishing eligibility
- Determining the amount of medical assistance
- Providing services for beneficiaries
- Assisting in a Medicaid-related investigation, prosecution, or civil or criminal proceeding

Regarding the release of beneficiary information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed the states that the requirements for the release of beneficiary information should parallel the limitations on payments. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration. However, if no payment could be

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

made to the agent because the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent.

Note: The manner in which the Medicaid program deals with the agent is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider. Agents or providers who furnish inaccurate, incomplete, or misleading information to SCDHHS regarding agent compensation issues may face sanctions.

Confidentiality of Alcohol and Drug Abuse Case Records

Federal law requires providers to observe more stringent rules when disclosing medical information from the records of alcohol and drug abuse patients than when disclosing information concerning other Medicaid beneficiaries. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found at 42 CFR Part 2.

SPECIAL / PRIOR AUTHORIZATION

Certain medical services must be authorized by SCDHHS (or its designee) prior to delivery in order to be reimbursable by Medicaid. Some of the services that are specifically subject to prior authorization and approval are as follows:

- Services provided outside of the South Carolina Medicaid Service Area (SCMSA). The SCMSA is South Carolina and adjacent areas within 25 miles of its borders. Providers should contact the PSC or submit an online inquiry for prior authorization guidelines.
- Services not routinely covered by Medicaid, or other services that require prior approval before payment or before service delivery as a matter of policy. Please refer to the appropriate section of this manual, contact the PSC, or submit an online inquiry for prior authorization guidelines.
- Services for which prepayment review is required.

Refer to program-specific sections of this manual for other services that must be authorized prior to delivery.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

CHARGE LIMITS

Except as described below for free care, providers may not charge Medicaid more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate or the provider's billed amount. Medicaid reimbursement is available for covered services under the State Medicaid Plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large.

BROKEN, MISSED, OR CANCELLED APPOINTMENTS

CMS prohibits billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The South Carolina Medicaid program utilizes National Correct Coding Initiative (NCCI) edits and its related coding policy to control improper coding.

The CMS developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits are to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary. NCCI edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI consist of two types of edits:

1) NCCI Procedure to Procedure (PTP) edits: These edits define pairs of HCPCS/CPT codes that

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

NATIONAL CORRECT CODING INITIATIVE (NCCI) (CONT'D.)

should not be reported together for a variety of reasons. These edits consist of a column one code and a column two code. If both codes are reported, the column one code is eligible for payment and the column two code is denied. In some instances an appropriate modifier may be added to one or both codes of an edit pair to make the code combination eligible for payment.

2) Medically Unlikely Edits (MUE): These edits define for each HCPCS/CPT code the number of units of service that is unlikely to be correct. The units of service that exceed what is considered medically necessary will be denied.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Services denied based on NCCI code pair edits or MUEs may not be billed to patients.

The CMS web page https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html provides overview information to providers on Medicaid's NCCI edits and links for additional information.

MEDICAID AS PAYMENT IN FULL

Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition to not charging the patient for any coinsurance or deductible amounts, providers may not charge the patient for the primary insurance carrier's copayment. Only applicable Medicaid copayments and services not covered by Medicaid may be billed to the beneficiary.

For beneficiaries enrolled in a Medicaid managed care option, the managed care entity must accept SCDHHS' capitated payment as payment in full for all services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL (CONT'D.)

covered by the capitation arrangement. Managed care network providers must accept their reimbursement from the managed care entity as payment in full. Only services not included in the specified benefits package or not otherwise covered by Medicaid may be billed to a beneficiary enrolled in a managed care option.

PAYMENTS LIMITATION

Medicaid payments may be made only to a provider, to a provider's employer, or to an authorized billing entity. **There is no option for reimbursement to a beneficiary.** Likewise, seeking or receiving payment from a beneficiary pending receipt of payment from the Medicaid program is not allowed, except where a copayment is applicable. By virtue of submitting a claim to Medicaid, a provider is agreeing to accept Medicaid as the payer.

REASSIGNMENT OF CLAIMS

In general, Medicaid payments are to be made only to the enrolled practitioner. However, in certain circumstances payment may be made to the following:

1. The employer of the practitioner, if the practitioner is required as a condition of employment to turn over fees to the employer
2. The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim
3. A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim
4. A business agent. Regulations found at 42 CFR Part 447, Subpart A, allow Medicaid to make payment for services to a provider's "business agent" such as a billing service or an accounting firm, only if the agent's compensation is:
   a) Related to the cost of processing the billing
   b) Not related on a percentage or other basis to the amount that is billed or collected
   c) Not dependent upon the collection of the payment

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

REASSIGNMENT OF CLAIMS (CONT'D.)

If the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, Medicaid is not allowed to make payment to the agent. Furthermore, providers are urged to seek advice regarding the HIPAA (Public Law 104-191) provisions when entering into such an agreement.

THIRD-PARTY LIABILITY

As a condition of eligibility for Medicaid, federal regulations at 42 CFR Part 433, Subpart D, require individuals to assign any rights to medical support or other third-party payment to the Medicaid agency (SCDHHS) and cooperate with the agency in obtaining such payments. The South Carolina Code §43-7-420 makes this assignment effective automatically upon application for Medicaid.

Medicaid providers may obtain information regarding third-party resources that are known to SCDHHS by utilizing the South Carolina Medicaid Web-based Claims Submission Tool. Third-party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation, and other casualty plans that may provide health insurance benefits under automobile or homeowner's coverages.

For Medicaid purposes, third-party resources are divided into two general categories: Health Insurance and Casualty Insurance.

Health Insurance

In general, health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. Unless otherwise permitted, a provider who accepts a Medicaid beneficiary as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

Should the third-party carrier deny payment or reduce payment to less than the Medicaid approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3 or other appropriate

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Health Insurance (Cont'd.)

materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139, claims for certain services to beneficiaries who have health insurance coverage may automatically reject if the third-party carrier has not been billed first.

If a claim is rejected for failure to bill third-party coverage, the provider must submit a new claim with the correctly coded information that documents payment or denial of payment by the third-party carrier.

While most claims are subject to coordination of benefits to ensure Medicaid is the payer of last resort, federal regulations exempt claims submitted for physicians' services under the Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Maternal Health, Title IV – Child Support Enforcement, and certain Department of Health and Environmental Control (DHEC) services under Title V. While providers are encouraged to file with any liable third party for these claim types, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program.

Premium Payment Project

Through the Premium Payment Project, SCDHHS is able to pay private health insurance premiums for Medicaid beneficiaries who are subject to losing coverage due to non-payment. SCDHHS will pay these premiums when said payment is determined to be cost effective.

Premium payment is usually cost effective for Medicaid beneficiaries with chronic medical conditions requiring long-term treatment such as cancer, end stage renal disease, chronic heart problems, congenital birth defects, and AIDS. Depending on the amount of the premium, the program may also be appropriate for beneficiaries with short-term costly health needs, such as pregnancy.

Providers of services to participating beneficiaries should consider Medicaid the payer of last resort and bill any liable third-party insurance plan prior to billing Medicaid.

Questions regarding the Premium Payment Project or referrals for beneficiary participation in this project should be directed to the Third-Party Liability– Medicaid Insurance Verification Services (MIVS) department by calling 1-888-289-0709 option 5, then option 4.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Casualty Insurance

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the beneficiary's attorney or the casualty insurance carrier, or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then SCDHHS will pursue reimbursement from any liable third party.

Provider Responsibilities – TPL

A provider who has been paid by Medicaid and **subsequently** receives reimbursement from a third party must repay to SCDHHS either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less. Some providers may choose to submit a repayment check accompanied by a completed Form for Medicaid Refunds (DHHS Form 205) identifying the third-party payer. Others providers may decide to submit a Claim Adjustment Form 130, which will allow them to void and/or replace a claim that resulted in under or overpayment. Examples of these forms can be found in the Forms section of this manual. For detailed information regarding both of these adjustment processes, please refer to Section 3 of this manual.

The Medicaid program makes payments to providers on behalf of beneficiaries for medical services rendered, but only to the extent that the beneficiary has a legal obligation to pay. If the beneficiary does not have a legal obligation to pay, then Medicaid will not make a payment. This means that if a beneficiary has third party insurance, including Medicare, SCDHHS's payment will be limited to the patient's responsibility (usually the deductible, co-

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Provider Responsibilities – TPL (Cont'd.)

pay and/or coinsurance.) The Medicaid reimbursement and third party payment cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer. A provider must not bill Medicaid for the difference between the payment received from a third party and the actual charges if the provider's third-party payment was determined under a "preferred provider" agreement. A "preferred provider" agreement is an agreement between the provider and the third party payer that establishes an amount that the provider is agreeing to accept as payment in full on its claims. Where such an agreement exists, Medicaid may only coordinate payment up to the lesser of the Medicaid allowed amount or the amount the provider has agreed to accept as payment in full from the third party payer.

The South Carolina Code §43-7-440(B) requires Medicaid providers to cooperate with SCDHHS in the identification of any third-party resource that may be responsible for payment of all or part of the cost of medical services provided to a Medicaid beneficiary. Upon receiving knowledge of third-party coverage that is not verified via the SCDHHS Web Tool, a provider is encouraged to notify SCDHHS's Division of Third-Party Liability of said coverage. The Health Insurance Information Referral Form may be used for this purpose. This form can be found in the Forms section of this manual.

The Division of Third-Party Liability must also be notified in writing if copies of claims submitted to Medicaid are released to anyone, including the beneficiary or the beneficiary's attorney. Before being released, the documents must clearly indicate that third-party benefits are assigned to SCDHHS pursuant to state law.

Providers should be aware that in no instance will SCDHHS pay any amount that is the responsibility of a third-party resource. If a provider releases copies of claims submitted to Medicaid and the release of those documents results in third-party payment being made to the beneficiary rather than to the provider, SCDHHS will not reimburse the provider for the amount of the third-party payment made to the beneficiary.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

TIME LIMIT FOR SUBMITTING CLAIMS

SCDHHS requires that only "clean" claims received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) be considered for payment. A "clean" claim is one that is edit and error-free and can be processed without obtaining additional information from the provider or from another third party. This time limit will not be extended on the basis of third-party liability requirements. However, the one-year time limit does not apply to Medicare cost sharing claims or to claims involving retroactive eligibility.

Medicare Cost Sharing Claims

Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later.

Retroactive Eligibility

Claims involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system **AND**
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Retroactive Eligibility (Cont'd.)

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

Please refer to Section 2 of the provider manual for any additional Retroactive Eligibility criteria that may apply.

Payment Information

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Providers should contact the PSC or submit an online inquiry for additional information.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

The South Carolina Department of Health and Human Services ensures the integrity of the Medicaid Program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies.

PROGRAM INTEGRITY

The Division of Program Integrity conducts post-payment reviews of all health care provider types including but not limited to hospitals (inpatient and outpatient) rural health clinics, Federally-qualified health clinics, pharmacies, ASCs, ESRD clinics, physicians, dentists, other health care professionals, speech, PT and OT therapists, CLTC providers, durable medical equipment providers, transportation providers, and behavioral and mental health care providers. Program Integrity uses several methods to identify areas for review:

- The toll-free Fraud and Abuse Hotline and the Fraud and Abuse email for complaints of provider and beneficiary fraud and abuse. The hotline number is 1-888-364-3224, and the email address is fraudres@scdhhs.gov.
- Each complaint received from the hotline or email is reviewed, and if the complaint is determined to involve either a Medicaid beneficiary or provider, a preliminary investigation is conducted to identify any indications of fraud and abuse.
- Referrals from other sources as well as ongoing provider monitoring that identify aberrant or excessive billing practices.
- The automated Surveillance and Utilization Review System (SURS) to create provider profiles and exception reports that identify excessive or aberrant billing practices.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

A Program Integrity review can cover several years' worth of paid claims data. (See "Records/Documentation Requirements" in this section for the policy on Medicaid record retention.) The Division conducts payment reviews, analysis of provider payments, and review of provider records, using statistical sampling and overpayment estimation when feasible, to determine the following:

- Medical reasonableness and necessity of the service provided
- Indications of fraud or abuse in billing the Medicaid program
- Compliance with Medicaid program coverage and payment policies
- Compliance with state and federal Medicaid laws and regulations
- Compliance with accepted medical coding conventions, procedures, and standards
- Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

The Division of Program Integrity ("Program Integrity") or its authorized entities, as described under Records Documentation/Requirements, General Information of Section 1, conduct both announced and unannounced desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. Program Integrity may conduct reviews, investigations, or inspections of any current or former enrolled provider, agency-contracted provider, or agent thereof, at any time and/or for any time period. During such reviews, Program Integrity staff will request medical records and related documents ("the documentation"). Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the entity into a usable form that allows authorized entities, described under Records Documentation/Requirements, General Information of

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

Section 1, the ability to review the record. Program Integrity or its designee(s) may either copy, accept a copy or may request original records. Program Integrity may evaluate any information relevant to validating that the provider received only those funds to which it is legally entitled. This includes interviewing any person Program Integrity believes has information pertinent to its review, investigation or inspection. Interviews may consist of one or more visits.

Program Integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements. The provider, therefore, must submit a copy of all requested records by the date requested by Program Integrity. Providers must not void, replace, or tamper with any claim records or documentation selected for a Program Integrity review activity, until the activity is finalized.

An overpayment arises when Program Integrity denies the appropriateness or accuracy of a claim. Reasons for which Program Integrity may deny a claim include, but are not limited to the following:

- The Program Integrity review finds excessive, improper, or unnecessary payments have been made to a provider
- The Provider fails to provide medical records as requested
- The provider refuses to allow access to records

In each scenario Medicaid must be refunded for the denied claims.

The provider is notified via certified letter of the post-payment review results, including any overpayment findings. If the Provider disagrees with the findings, the provider will have the opportunity to discuss and/or present evidence to Program Integrity to support any disallowed payment amounts. If the parties remain in disagreement

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

following these discussions, the Provider may exercise its right to appeal to the Division of Appeals and Hearings.

If the provider does not contest Program Integrity's finding, or the appeal process has concluded, the provider will be required to refund the overpayment by issuing payment to SCDHHS or by having the overpayment amount deducted from future Medicaid payments. Termination of the provider enrollment agreement or contract with SCDHHS does not absolve the provider of liability for any penalties or overpayments identified by a Program Integrity review or audit.

Sanctions including but not limited to suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:

- Allow immediate access to records
- Repay in full the identified overpayment
- Make arrangements for the repayment of identified overpayments
- Abide by repayment terms
- Make payments which are sufficient to remedy the established overpayment

In addition, failure to provide requested records may result in one or more of the following actions by SCDHHS:

- Immediate suspension of future payments
- Denial of future claims
- Recoupment of previously paid claims

Any provider terminated for cause, suspended, or excluded will be reported to the Centers for Medicare and Medicaid Services (CMS) and U.S. Department of Health and Human (HHS) Office of Inspector General (OIG).

PREPAYMENT REVIEW

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by Program Integrity/SUR, or other grounds as determined by Program Integrity/SUR.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PREPAYMENT REVIEW (CONT'D.)

Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers may be required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (*e.g.,* clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were billed appropriately, and according to South Carolina Medicaid policies and procedures. Services inconsistent with South Carolina Medicaid policies and procedures are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied.

Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by Program Integrity/SUR. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions as defined in the rules in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1.

RECOVERY AUDIT CONTRACTOR

The South Carolina Department of Health and Human Services, Division of Program Integrity, has contracted with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71. Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. The Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, with an effective date of

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

January 1, 2012. States are required to contract with Medicaid RACs "in the same manner as the Secretary enters into contracts" with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor.

Under this rule, State contracts with Medicaid Recovery Audit Contractors must include the following requirements (or the State must obtain an exemption from CMS for the requirement):

- That each Medicaid RAC hires a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy licensed to practice in that State.

  Note: SCDHHS has an approved State Plan Amendment to allow the RAC to have a part-time, in-state medical director who is also a practicing physician, in lieu of a 1.0 FTE medical director.

- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are not required for the effective review of Medicaid claims)
- An education and outreach program for providers, including notification of audit policies and protocols
- Minimum customer service measures such as a toll-free telephone number for providers and mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request
- Notifying providers of overpayment findings within 60 calendar days
- A 3 year maximum claims look-back period and
- A State-established limit on the number and frequency of medical records requested by a RAC.

  Note: SCDHHS has an approved State Plan Amendment to allow the RAC to review claims that are older than three years. The RAC will only be allowed to review claims older than three years upon written permission of the agency.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

HMS (Health Management Systems, Inc.) is the current Recovery Audit Contractor for the SCDHHS Division of Program Integrity.

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

The Beneficiary Explanation of Medical Benefits Program allows Medicaid beneficiaries the opportunity to participate in the detection of fraud and abuse. Each month the Division of Program Integrity randomly selects several hundred beneficiaries for whom claims for services were paid. These beneficiaries are provided with an Explanation of Medical Benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Beneficiaries are requested to verify that they received the services listed. The Division of Program Integrity investigates any provider when the beneficiary denies having received the services.

BENEFICIARY OVERSIGHT

The Division of Program Integrity performs preliminary investigations on allegations of beneficiary fraud and abuse. This includes, but is not limited to, beneficiaries who are alleged to have:

- Submitted a false application for Medicaid
- Provided false or misleading information about family group, income, assets, and/or resources and/or any other information used to determine eligibility for Medicaid benefits
- Shared or lent their Medicaid card to other individuals
- Sold or bought a Medicaid card
- Diverted for re-sale prescription drugs, medical supplies, or other benefits
- Obtained Medicaid benefits that they were not entitled to through other fraudulent means
- Other fraudulent or abusive use of Medicaid services

Program Integrity reviews the initial application and other information used to determine Medicaid eligibility, and makes a fraud referral to the State Attorney General's Office or other law enforcement agencies for investigation

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

BENEFICIARY OVERSIGHT (CONT'D.)

as appropriate. Beneficiary cases will also be reviewed for periods of ineligibility not due to fraud but which still may result in the unnecessary payment of benefits. In these cases the beneficiary may be required to repay the Medicaid services received during a period of ineligibility.

Complaints pertaining to beneficiaries' misuse of Medicaid services can be reported using the Fraud and Abuse Hotline (1-888-364-3224) or fraud email at fraudres@scdhhs.gov.

MEDICAID BENEFICIARY LOCK-IN PROGRAM

The Division of Program Integrity manages a Beneficiary Lock-In Program that screens all Medicaid members against clinically-vetted criteria designed to identify drug-seeking behavior and inappropriate use of prescription drugs. The Beneficiary Lock-In Program addresses issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary claims data in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy. Beneficiaries who are enrolled in the Lock-In Program with an effective date of October 1, 2014 and forward will remain in the program for two years. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the beneficiary to obtain emergency medication and/or go to another pharmacy should the first pharmacy provider be unable to provide the needed services.

DIVISION OF AUDITS

Medicaid providers, who contract with SCDHHS for services, including state agencies, may be audited by the SCDHHS Division of Audits. The SCDHHS Division of Audits was formed to assist the agency in the management, assessment, and improvement of agency programs, services, and operations. The Division of Audits accomplishes these goals by reviewing and evaluating programs administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost-effective manner.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

DIVISION OF AUDITS (CONT'D.)

In performing its audits, the Division of Audits follows generally accepted auditing standards (GAGAS). The Division of Audits performs different types of audits of Medicaid providers and programs, including:

- Performance audits that provide an independent assessment of the program outcomes and the management of resources. These audits address the effectiveness, efficiency, and adequacy of program results.
- Audits of contracts with health care providers and other state agencies to ensure compliance with contract terms and conditions for Medicaid service delivery and administration
- Audits to confirm the accuracy and allowability of costs and other financial information reported to SCDHHS.

PAYMENT ERROR RATE MEASUREMENT

The South Carolina Medicaid program, along with the Medicaid programs in other states, is required to comply with the CMS Payment Error Rate Measurement (PERM) program, which was implemented in federal fiscal year 2007. Each state will be reviewed every three years. PERM requires states to submit a statistically valid sample of paid Medicaid claims to a federal contractor, which will review for compliance with payment rates and state Medicaid policies, and will determine whether medical necessity for the service is adequately documented in the medical record. Providers who are chosen for the sample will be required to submit all applicable medical records for review; however, for most providers only one claim will be chosen for the sample. Providers who fail to send in the requested documentation will face recoupment of the Medicaid payment for the claim in question. In addition if the CMS PERM contractor determines that a Medicaid claim was paid in error, SCDHHS will be required to recoup the payment for that claim. PERM will combine the errors found in each state in order to establish a national Medicaid error rate.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSIONS / PROVIDER EXCLUSIONS / TERMINATIONS

FRAUD

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity will conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. Suspicion of fraud can arise from any means, including but not limited to fraud hotline tips, provider audits and program integrity reviews, RAC audits, data mining, and other surveillance activities. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a Medicaid Managed Care Organization (MCO), Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a beneficiary is referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

PAYMENT SUSPENSIONS

Medicaid payments to a provider may be withheld upon credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Suspension of Provider Payments for Credible Allegation of Fraud

SCDHHS will suspend payments in cases of a credible allegation of fraud. A "credible allegation of fraud" is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations

SCDHHS has flexibility in determining what constitutes a "credible allegation of fraud." Allegations are considered to be credible when they have indications of reliability based upon SCDHHS' review of the allegations, facts, and evidence on a case-by-case basis.

Notice of Suspension

SCDHHS will suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity. Payments may be suspended without first notifying the provider of the intention to suspend payments. SCDHHS will send notice of its suspension of program payments within the following timeframes:

- Within five business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice
- Within 30 calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice

The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider
- Legal proceedings related to the provider's alleged fraud are completed

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Referrals to the Medicaid Fraud Control Unit

Whenever an investigation leads to the initiation of a payment suspension in whole or part, SCDHHS will make a fraud referral to the South Carolina Medicaid Fraud Control Unit.

Good Cause not to Suspend Payments or to Suspend Only in Part

SCDHHS may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds;
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed;
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
    - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
    - The individual or entity serves a large number of beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Law enforcement declines to certify that a matter continues to be under investigation;
- SCDHHS determines that payment suspension is not in the best interests of the Medicaid program.

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Good Cause not to Suspend Payments or to Suspend Only in Part (Cont'd.)

individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
  - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
  - The individual or entity serves beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
- SCDHHS determines the following:
  - The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
  - A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension is not in the best interest of the Medicaid program.

Even if SCDHHS exercises the good cause exceptions set forth above, this does not relieve the agency of its obligation to refer a credible allegation of fraud to the Medicaid Fraud Control Unit.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS

Federal regulations that give States the authority to exclude providers for fraud and abuse in the Medicaid program are found at 42 CFR Part 1002, Subparts A and B. Exclusion means that a health care provider, either an individual practitioner or facility, organization, institution, business, or other type of entity, cannot receive Medicaid payment for any health care services rendered. Exclusions from Medicaid, as well as the State Children's Health Insurance Program (SCHIP), may be the result of:

- Conviction of a criminal offense related to delivery of services in a health care program
- Conviction of health care fraud under either Federal or State laws
- Conviction of the patient neglect or abuse in connection with delivery of health care
- Excessive claims or furnishing of unnecessary or substandard items and services
- Failure to comply with financial responsibilities and obligations
- Adverse action by a licensing board

Exclusions can be initiated by either federal authorities such as the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) or by the State Medicaid agency. An excluded individual may be a licensed medical professional, such as a physician, dentist, or nurse, but exclusion is not limited to these types of individuals. The ban on Medicaid funding can extend to any individual or entity providing services that are related to and reimbursed, directly or indirectly, by a Medicaid program.

In addition, the HHS-OIG and/or SCDHHS may exclude an entity, including managed care organizations, if someone who is an owner, an officer, an agent, a director, a partner, or a managing employee of the entity has been excluded.

Any medical provider, organization, or entity that accepts Medicaid funding, or that is involved in administering the Medicaid program, should screen all employees and contractors to determine whether any of them have been excluded. Any individual or entity which employs or contracts with an excluded provider cannot claim Medicaid

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS (CONT'D.)

reimbursement for any items or services furnished, authorized, or prescribed by the excluded provider.

Federal regulations further require that any party who is excluded from participation in Medicare under 42 CFR Part 1001 must also be excluded from the Medicaid program. Medicaid payment is not available for services furnished directly by, or under the supervision of, an excluded party.

The HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Visit the HHS-OIG website at http://www.oig.hhs.gov/fraud/exclusions.asp to search and/or download the LEIE.

SCDHHS also maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) on our website. Visit the Provider Information page at http://provider.scdhhs.gov for the most current list of individuals or entities excluded from South Carolina Medicaid.

PROVIDER TERMINATIONS

"Termination" means that the SCDHHS has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Under Federal regulations established by the Affordable Care Act, SCDHHS has established the reasons under which a provider can be terminated from the Medicaid program "for cause"; see SCDHHS PE Policy-03, Terminations.

ADMINISTRATIVE SANCTIONS

State regulations concerning administrative sanctions in the Medicaid program are found in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1. SCDHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

- Educational intervention
- Post payment review
- Prepayment review

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

ADMINISTRATIVE SANCTIONS (CONT'D.)

- Peer review
- Financial sanctions, including recoupment of overpayment or inappropriate payment
- Termination or exclusion
- Referral to licensing/certifying boards or agencies

OTHER FINANCIAL PENALTIES

The State Attorney General's Office may also impose financial penalties and damages against a provider who has been determined to be guilty of fraud or convicted of a crime related to participation in the Medicaid or Medicare programs.

The HHS-OIG may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003.

FAIR HEARINGS

Proposed South Carolina initiated exclusion or termination from the Medicaid program, as well as recoupment of an overpayment identified by Program Integrity, may be appealed within 30 days of imposition of the sanction. (See "Appeals Procedures" elsewhere in this section.)

Any party who has been excluded or terminated from the Medicaid program as a result of a similar action by Medicare may exercise appeal rights as set forth in the written notice from the HHS-OIG. Appeals to the HHS-OIG shall be processed in accordance with 42 CFR 1001.2007. A party so excluded shall have no right to separate appeal before SCDHHS.

REINSTATEMENT

Re-enrollment in Medicaid by formerly excluded providers is not automatic. The CFR [42 CFR 1002.215(a)] gives states the right to review requests for reinstatement and to grant or deny the requests.

Before a request for re-enrollment in Medicaid will be considered, the provider must have an active, valid license to practice and must not be excluded from Medicaid or Medicare by the HHS-OIG.

It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the HHS-OIG, then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

REINSTATEMENT (CONT'D.)

SCDHHS may deny reinstatement to the Medicaid program based on, but not limited to, any one or a combination of the following:

1. The likelihood that the events that led to exclusion will re-occur.
2. If, since the date of the original exclusion, the provider has been convicted of fraud related to the delivery of services in a healthcare program, or has been convicted or had his license suspended or revoked due to failure to follow standards of care and/or patient harm or abuse.
3. If new information is provided that such conduct (as described above) occurred prior to the date of the exclusion but was not known to SCDHHS at the time.
4. If the provider has been excluded or had billing privileges terminated from Medicaid and/or Medicare by any state or by the HHS-OIG.
5. Any terms or conditions associated with reinstatement by the appropriate licensing board or regulatory agency, or by the HHS-OIG.
6. Whether all fines, overpayments, or any other debts owed to the Medicaid program have been paid or arrangements have been made to fulfill these obligations.

All requests for re-enrollment in Medicaid will be considered by SCDHHS on an individual basis and on their own merit.

Any appeal of a denial of reinstatement will be in accordance with SCDHHS appeals policies and procedures as provided by South Carolina Code of Laws R. 126-150.

A terminated provider will also be required to reapply and be reenrolled with the Medicaid program if they wish billing privileges to be reinstated.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

SCDHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in South Carolina Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

The South Carolina Medicaid appeals process is not a reconsideration or claims review process. It is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should contact the PSC or submit an online inquiry for assistance to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of SCDHHS, a provider wishing to file an appeal must request a hearing in writing and submit a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Appeals may be filed:

Online: www.scdhhs.gov/appeals

By Fax: (803) 255-8206

By Mail to:

Division of Appeals and Hearings
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

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SECTION 2

POLICIES AND PROCEDURES

TABLE OF CONTENTS

SECTION 2

POLICIES AND PROCEDURES

TABLE OF CONTENTS

SECTION 2

POLICIES AND PROCEDURES

TABLE OF CONTENTS

SECTION 2

POLICIES AND PROCEDURES

TABLE OF CONTENTS

SECTION 2

POLICIES AND PROCEDURES

TABLE OF CONTENTS

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

A hospital is defined as a general acute care institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) Program.

All hospitals must be enrolled in the South Carolina Medicaid Program. In-state hospitals must also contract with the South Carolina Department of Health and Human Services (SCDHHS) to provide inpatient and outpatient services. Out-of-state hospitals within the medical service areas (normally within 25 miles of the state's borders) may follow the same contractual procedures as in-state providers. Please refer to Section 1, Requirements for Provider Participation, for instructions regarding provider enrollment.

Hospitals located more than 25 miles from the South Carolina borders do not contract with SCDHHS. These hospitals must complete an enrollment form and sign a provider agreement. Out-of-state referrals by physicians when the needed services are not available within the South Carolina Medical Service Area must be pre-authorized. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States. See "Out-of-State Services" in this section for more information.

In order to receive Medicaid reimbursement for services, hospitals must meet the program requirements outlined in this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

Certification

Hospitals that are currently certified to participate in Title XVIII (Medicare) are deemed to meet all of the requirements for participation in Title XIX (Medicaid). Additionally, the following conditions must be met:

1. **Personnel**

   All patients must be treated by or under the direct supervision of a physician licensed to practice medicine in the state of South Carolina. When ancillary personnel are to be used in patient care, the written plan of care must indicate the extent of their involvement. The physician must demonstrate continued interest by professional encounters during the course of treatment. Evidence of staff supervision must be documented in the patient's record when interns and residents are providing a service. Please refer to Professional Services for policy on physician supervision.

2. **Emergency Service Personnel**

   A physician must screen all patients who arrive for treatment in the emergency room to assess level of care as mandated by COBRA/OBRA legislation.

3. **Supervision**

   SC Medicaid requires a supervising entity (physician, dentist, or any program that has a supervising health professional component) to be physically located in SC or within the 25-mile radius of the SC border.

Certification, Licensing, Contracts, and Enrollment

For Certification and Licensing contact:

Department of Health and Environmental Control (DHEC)
Division of Certification and Licensing
2600 Bull Street
Columbia, SC 29201

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Certification, Licensing, Contracts, and Enrollment (Cont'd.)

For Medicaid Contract Negotiation contact:

Department of Health and Human Services
Contracts Division
Post Office Box 8206
Columbia, SC 29202-8206

To request a Medicaid enrollment packet, please contact Medicaid Provider Enrollment via the SCDHHS Provider Service Center (PSC) at 1-888-289-0709, submit an online request at http://www.scdhhs.gov/contact-us, or you may submit a request in writing to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

Contracts

In-state hospitals that want to contract with SCDHHS must submit a written request for participation to:

Department of Health and Human Services
Contracts Division
Post Office Box 8206
Columbia, SC 29202-8206

Copies of the Medicare/Medicaid Certification and Transmittal, CLIA Certification, and ESRD Certification, if appropriate, must accompany the request. The provider will then be requested to submit cost report information. New facilities will be requested to submit a report of projected costs. If this information is satisfactory, SCDHHS will send the provider two copies of the contract and Provider Enrollment forms. The provider will sign the contracts, complete the enrollment forms, and return all documents to the Contracts Division. The contracts will then be signed by the director of SCDHHS and one copy will be returned to the provider along with unique six-character provider numbers, one for inpatient and another for outpatient services. Provider numbers should be used on all claim forms, inquiries, and adjustment requests. Hospitals that bill for professional services provided by hospital-based physicians will be assigned an additional provider number for billing these services

Clinical Laboratory Improvement Act (CLIA)

In accordance with federal regulations (42 CFR 493.1809), SCDHHS requires that all laboratory testing sites, including hospital laboratories, have a CLIA Certificate of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Clinical Laboratory Improvement Act (CLIA) (Cont'd.)

Waiver, Certificate of Registration, or Regular Certificate (issued after successful completion of the lab survey), along with a unique 10-digit number, in order to perform laboratory tests. This 10-digit number must be on file with SCDHHS.

BENEFICIARY REQUIREMENTS

Eligibility

Medicaid pays for covered medical services for individuals who are eligible during the month in which the services are rendered. Medicaid beneficiaries enrolled in Waiver programs may have limits and restrictions for Medicaid-reimbursable services. Refer to Section 1 for further information on Medicaid eligibility.

Medicaid beneficiaries in the following coverage groups are eligible for limited services. Please refer to Special Coverage Groups in this section for additional information on these groups:

- Family Planning
- Hospice

Beneficiaries in the following programs may have certain restrictions in obtaining covered services. For additional information on these programs refer to the Medicaid Managed Supplement.

- Managed Care Organizations (MCOs)
- Medical Homes Network – Medically Complex Children's Waiver (MCCW)

Medicare/Medicaid (Dually Eligible)

Medicare is a hospital and medical insurance program administered by the Social Security Administration for eligible persons who have reached 65 years of age or have been determined blind, totally and permanently disabled, or who have end stage renal disease. Dually eligible individuals also qualify for Medicaid coverage.

Medicare has two parts. Part A (Hospital Insurance) pays the expenses of a patient in a hospital, skilled nursing facility, or at home when receiving services provided by a home health agency. Part B (Medical Insurance) helps pay for physician services, outpatient hospital services, inpatient ancillary charges when Part A benefits are

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medicare/Medicaid (Dually Eligible) (Cont'd.)

exhausted or nonexistent, medical services and supplies, home health services, outpatient physical therapy, and other health care services.

Medicaid will pay the allowed amount less the amount paid by Medicare or the coinsurance, deductible, and blood deductible amount, whichever is less. Medicaid does not cover any charges during Lifetime Reserve Days (LRD), the 91st to 150th day, or the continued stay when a patient has elected to use or not to use LRD. Medicaid does not cover a continued stay after LRDs are exhausted. Subsequent admissions in the same spell of illness are covered. Refer to Section 3 for billing guidelines for Lifetime Reserve Days.

When a beneficiary's Medicare eligibility is limited to Part B coverage only, Medicaid pays for all inpatient services except for those ancillary services covered by Part B. It is very important to see the beneficiary's Medicare card to determine the extent of his or her coverage. If the Medicare card is not available, you may use the Medicare Direct Data Inquiry (DDI) to verify eligibility.

Claims submitted to SCDHHS that have been denied by Medicare for medical necessity based on Local Coverage Determination (LCD) will not be paid by Medicaid. If Medicare has an LCD in which the service/test is considered to be not medically necessary, then Medicaid will <u>not</u> pay the deductible, blood deductible, or co-insurance for these non-covered charges. The notice of non-coverage by Medicare to notify patients that the service(s) is not covered may also serve as the notification to the patient that Medicaid will not cover the service. If the patient is given advance notice of non-coverage then the patient may be billed for the non-covered charges.

All services rendered to dually eligible Medicare/Medicaid patients should be filed to Medicare first. Refer to Section 3 for billing guidelines.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medicare/Medicaid (Dually Eligible) (Cont'd.)

Days in a Spell of Illness	Medicare Part A	Medicaid
1 through 60	Pays all but the deductible, plus blood deductibles of three pints	Pays deductible including blood*
61 through 90	Pays all but coinsurance, equal to one-quarter of deductible per day	Pays daily coinsurance*
91 through 150	Lifetime Reserve Days – Pays all but coinsurance, equal to one-half of deductible per day	Does not pay during this period
151+	Does not pay after Lifetime Reserve Days are exhausted unless spell of illness is broken for 60 days	Does not pay during this period

*** Medicaid will pay the allowed amount less the amount paid by Medicare or the coinsurance, deductible, and blood deductible amount, whichever is less.**

As of January 2018:
Deductible = $1,340.00
Regular Coinsurance = $335 x 30 = $10,050
Total = $1,340 + $10,050 = $11,390
Medicaid Blood Deductible = $100 per unit (not to exceed 3)
Outpatient Deductible = $183.00
Outpatient Coinsurance = 20% of Medicare allowed charges

As of January 2017:
Deductible = $1,316.00
Regular Coinsurance = $329 x 30 = $9,870
Total = $1,316 + $9,870 = $11,186
Medicaid Blood Deductible = $100 per unit (not to exceed 3)
Outpatient Deductible = $183.00
Outpatient Coinsurance = 20% of Medicare allowed charges

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medicare/Medicaid (Dually Eligible) (Cont'd.)

As of January 2016:
Deductible = $1,288.00
Regular Coinsurance = $322 x 30 = $9,660
Total = $1,288 + $9,660 = $10,948
Medicaid Blood Deductible = $100 per unit
(not to exceed 3)
Outpatient Deductible = $166.00
Outpatient Coinsurance = 20% of Medicare allowed charges

Medicaid as Primary Insurer

Medicaid is considered the payer of last resort. The programs listed below are some exceptions to the payer of last resort mandate. In these cases Medicaid must be billed as the primary insurer.

- BabyNet
- Best Chance Network
- Black Lung
- Community Health
- Crime Victims Compensation Fund
- CRS Children's Rehabilitative Services
- DHEC Family Planning (DHEC Maternal Child Health)
- Indian Health
- Migrant Health
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

UTILIZATION REVIEW

Quality Improvement Organization (QIO)

SCDHHS contracts for external utilization review services with a Quality Improvement Organization (QIO). Keystone Peer Review Organization, Inc. (KEPRO) is the current QIO contractor. The QIO review consists of:

- Pre-surgical review for all hysterectomies
- Select preauthorization review

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Quality Improvement Organization (QIO) (Cont'd.)

- Support documentation review

All Medicaid hospital claims are subject to both prepayment and postpayment review by SCDHHS and/or the QIO. Should either determine that procedures were not followed, services were not medically necessary or the proper diagnosis and procedure codes were not indicated (resulting in improper DRG coding for inpatient claims or upcoding for outpatient claims), payment will be denied or reduced. If the claim has been paid, action will be taken to recoup the payment.

SCDHHS reserves the right to review retrospectively any case that has received prior approval to assure accuracy and compliance with South Carolina Medicaid guidelines and federal requirements. Telephone or written approval is not a guarantee of Medicaid payment. All cases are subject to retrospective review to validate the medical record documentation.

Pre-Surgical Justification for Elective Hysterectomies

All prior approval requests for hysterectomies must be submitted to KEPRO. Prior authorization must be obtained even if the surgery follows a delivery. Providers should use the Request for Surgical Justification for Hysterectomy Form and the Consent for Sterilization Form with each request. There is a 30 day wait period from the date the Consent form is signed before the surgery is performed.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@kepro.com

For urgent and emergent hysterectomy cases the 30 day wait is not required, however the reason for the emergency must be provided by the physician. The claim will be reviewed retrospectively. Please refer to Special Coverage Issues in this section for additional Medicaid policies for hysterectomies.

Cases that do not meet the QIO criteria will be referred for physician review. The physician will use clinical judgment to determine whether the proposed treatment was appropriate to the individual circumstances of the referred case. Pre-approved cases will not be subject to retrospective review by the QIO. However, SCDHHS

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Pre-Surgical Justification for Elective Hysterectomies (Cont'd.)

reserves the right to review any paid claim and recoup payment when medical necessity requirements are not met.

The patient and physician shall make the final decision as to whether to undergo surgery. Medicaid will not sponsor the hospital-related expenses associated with the surgery if the QIO physician consultant determines that the proposed surgery is not appropriate.

Documentation Requirements

The appropriate documentation must appear in the patient's medical record, including the illness, history, physical findings, diagnosis, and prescribed treatment to justify medical necessity for the level of service reimbursed. **Documentation must be legible** and must also meet the standards outlined in Section 1 of this manual.

Medicaid requires that providers obtain authorization from each patient to release to SCDHHS any medical information necessary for processing Medicaid claims. Compliance with this requirement is part of the enrollment process

Support Documentation

All support documentation must be attached hard copy to the UB-04.

A list of procedure codes requiring support documentation from the QIO can be found in Section 4 of this manual.

Prior Authorization

SCDHHS contracts with a quality improvement organization (QIO), KEPRO, to perform pre-surgical review of select surgical procedures. Providers must submit all appropriate clinical information along with the Request For Prior Approval Review to KEPRO.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@kepro.com

Prior approval requests for beneficiaries enrolled in a Managed Care Organization (MCO) must be handled by the MCO. For a current list of participating MCOs with plan contact information, see the Managed Care Supplement.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Authorization (Cont'd.)

Requesting providers are responsible for providing the PA number to any facility or medical provider who will submit a Medicaid claim related to the service.

A list of procedure codes requiring prior authorization from the QIO can be found in Section 4 of this manual.

Instructions for Obtaining Prior Authorization

The responsibility for obtaining pre-admission/pre-procedure review rests with either the attending physician or the hospital. The requesting provider must submit all necessary documents including the Request for Prior Approval Review to KEPRO.

The QIO reviewer will screen the medical information provided using the appropriate QIO or InterQual criteria for non-physician review.

If criteria are met, the procedure will be approved and an authorization number assigned. The provider will be notified of the approval and authorization number. Enter this number in field 63 of the UB-04.

If criteria are not met or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the admission/procedure based on the initial information provided, he or she will make a reasonable effort to contact the attending physician for additional supporting documentation.

The physician reviewer will document any additional information provided, as well as his or her decision regarding the medical necessity and appropriateness of the procedure.

Review personnel will assign an approval number (if the procedure is approved), and notification of the authorization number will be given to the physician's office.

If the physician reviewer cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. The QIO review personnel will notify the attending physician's office of the denial.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Procedure for Reconsideration of Denial of Prior Approval

- The physician may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the procedure. Reconsideration may be requested whether the case was a pre-procedure or post-procedure review. The request should be in writing to KEPRO.
- If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFR 473.38).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicaid will only pay for services that are medically necessary and are covered services as outlined in this manual. "Medically necessary" services include those services directed toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain. The service must (1) be consistent with the diagnosis and treatment of the patient's condition, (2) be in accordance with standards of good medicine, (3) be required for reasons other than the convenience of the patient or the physician, and (4) be performed in the least costly setting required by the patient's condition. Federal regulations require hospitals to certify the accuracy of the diagnostic and procedural information, as well as to attest to the accuracy of each claim before it is submitted.

Reimbursement for inpatient hospital admissions is made to a hospital on a prospective payment basis. All covered services are included in this payment, and the Medicaid beneficiary cannot be billed for any of these services. **Services specifically excluded from coverage may be billed to Medicaid beneficiaries provided they are advised in advance that such services are non-covered.**

Reimbursement for outpatient hospital services is based on a fee schedule. All covered services are paid by one of three reimbursement types. A Medicaid beneficiary cannot be billed for a non-covered service unless he or she is advised before the service is rendered that it is non-covered. **A Medicaid beneficiary cannot be charged for services if he or she is unaware of his or her responsibility.**

When a patient is Medicaid eligible for only part of an inpatient hospital stay, the non-covered portion may be billed to the patient. However, charges for the entire admission should appear on the UB-04 and the system will prorate accordingly.

When an outpatient hospital stay crosses two months and the patient is only eligible for Medicaid for one of the months, the non-covered portion may be billed to the patient. Only bill Medicaid for the outpatient services that

PROGRAM SERVICES (CONT'D.)

occurred during the period that the patient was Medicaid eligible.

If the hospital stay is for a non-covered procedure only, then no payment will be made by Medicaid. The patient may be billed. If the hospital stay is for a procedure that is covered and a procedure that is non-covered, payment for the covered procedure can be made. The patient may be billed for the non-covered procedure. Charges for the non-covered procedure should appear in the non-covered column on the UB-04. Refer to Section 3 for specific billing instructions.

INPATIENT HOSPITAL SERVICES

An inpatient is a patient who is admitted to a medical facility on the recommendation of a physician or dentist, is receiving specialized institutional and professional services on a continuous basis, and is expected to require such specialized services for a period generally greater than 24 hours. Exceptions to the 24-hour requirement for inpatients include but are not limited to deaths (including ER admission), false labor, deliveries, and medical transfers.

Inpatient services are defined as those items and services which are medically appropriate to the inpatient hospital setting and meet the medical necessity requirements outlined in the criteria and policies of the QIO. These items and services must be directed and documented by a licensed physician in accordance with hospital bylaws in a facility meeting hospital criteria.

Inpatient hospital reimbursement is based on the hybrid prospective payment system methodology. All services rendered during an inpatient stay are included in the diagnosis related group (DRG) reimbursement. Outpatient services that result in an inpatient admission are deemed to be inpatient services and are included in the DRG payment. Outpatient services rendered on the day of admission are included in the DRG payment regardless of relation to the inpatient admission. All outpatient services rendered during an inpatient stay are included in the DRG payment, including charges for tests or procedures performed by another general acute care hospital. In such cases the admitting hospital is responsible for reimbursing the performing hospital for its services. The formulas used to calculate inpatient hospital payments are located in Section 3 of this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

INPATIENT HOSPITAL SERVICES (CONT'D.)

The South Carolina Medicaid State Plan limits coverage of inpatient hospital services to general acute care hospital and psychiatric hospital services for individuals under age 21. Inpatient rehabilitative services provided in a distinct medical rehabilitation facility or a separately licensed specialty hospital are not reimbursable. Medicaid will reimburse rehabilitation services rendered to Medicaid beneficiaries on an inpatient or outpatient basis at a general acute care hospital.

Prior Authorizations for Inpatient Admissions

All acute care hospital admissions, except deliveries and births, must be prior authorized by the QIO, KEPRO. Requests for emergency admissions must be made within five business days of the admission. KEPRO will use McKesson's InterQual criteria for medical necessity and will provide a determination within 24 hours of the request for non-emergency situations. If a second level consultant's review is required, a determination will be made by the QIO within two business days of the initial request. The prior authorization request could be initiated by either the physician or the hospital. The prior authorization number, however, must be shared with all providers involved with the admission.

Patients with Medicare as primary payer are only required to obtain a prior authorization if Medicare does not make a payment or the service is not covered by Medicare and Medicaid then becomes primary. Please note that Managed Care Organizations will continue to authorize services according to their specific plans for enrolled beneficiaries (members).

Requests for prior authorizations from KEPRO may be submitted using one of the following methods.

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@kepro.com

Covered Days

The number of days of care provided to Medicaid patients is always counted in units of full days. For Medicaid purposes, a day begins at midnight even if the hospital uses a different definition of a day. The day of discharge is not counted as a covered day. Services provided on the day of discharge beyond checkout time for the comfort or convenience of the patient are not covered under Medicaid and may be billed to the patient.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outliers

A cost outlier occurs if a hospital's estimated costs exceed a specified amount above the DRG base payment. The Medicaid Management Information System (MMIS) will automatically calculate outliers.

Cost outlier thresholds are established using statewide data. Additional information regarding these calculations may be obtained by calling the Division of Acute Care Reimbursement at (803) 898-1040.

Admission/Discharge Criteria

An admission occurs when the acute inpatient hospital criteria are met and the physician expects the patient to remain in the hospital longer than 24 hours. These criteria requirements are outlined in the criteria and policies of the QIO under contract with SCDHHS. If the acute inpatient hospital criteria are met, an admission is then appropriate regardless of the time spent in the hospital.

A person is considered discharged when formally released from an acute care facility. A patient is also considered discharged (1) when the patient is transferred to another acute care facility, (2) when the patient is discharged to a long term care facility, (3) when the patient dies, (4) when the patient leaves against medical advice, or (5) when the patient is transferred to a psychiatric or rehabilitation unit.

Types of Inpatient Admissions

Elective Admission

An elective admission occurs when a patient's condition requires non-urgent treatment that can be anticipated or scheduled in advance without posing a threat to the patient's health outcome. When a physician calls to schedule an admission for non-urgent treatment and finds a bed immediately available and admits the patient, the admission is still considered elective. Admissions for elective procedures must take place on a weekday unless there is a valid medical reason for a weekend admission. Friday is considered part of the weekend.

One-Day Admissions

A one-day admission occurs when a patient is admitted to a hospital one day and discharged anytime during the next calendar day. This stay may be billed as an inpatient admission when the admission criteria have been met.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Admission From an Observation Unit

When a patient is admitted to the hospital from an observation stay, bill the date the beneficiary was switched from observation to inpatient status as the first day of the inpatient admission. Only if the observation stay is unrelated to the inpatient admission, excluding the day of admission, can the observation days be billed as outpatient services. Observation stays related to and within 72 hours of the inpatient admission are considered inpatient services and are included in the DRG payment. Refer to Pre-Admission Services (72-hour Rule).

Readmission

A readmission occurs when a patient is admitted to the same or any other facility within 30 days of discharge for the same DRG or general diagnosis as the original admission. Readmissions are subject to postpayment review and may be paid as two separate admissions unless the postpayment reviewer denies one of the admissions.

Transfers

A patient is considered transferred when moved from one acute inpatient facility to another acute inpatient facility, or when transferred to a psychiatric unit or a rehabilitation unit within the acute inpatient facility. A transfer does not occur until the patient is actually moved by the transport team. SCDHHS will consider a transfer for social reasons provided the medical records justify the need for the transfer and the patient still requires acute hospital care.

Segmented Care/Leave of Absence

A hospital may place a patient on a leave of absence (LOA) when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples include but are not limited to situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. The hospital stay must be billed as one admission and charges for the LOA days must be shown as non-covered.

Mother/Newborn Admissions

Charges for the mother and newborn child must be separated and submitted on two claims. All charges associated with the mother must be submitted on one claim using the mother's Medicaid ID number. Charges associated with the newborn child must be submitted on another claim using the newborn's Medicaid ID number.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Mother/Newborn Admissions (Cont'd.)

Routine circumcisions for newborns are non-covered. Providers should contact the SCDHHS county office for a newborn's Medicaid Number. The SCDHHS county office listing is located on the website at https://www.scdhhs.gov/site-page/where-go-help.

Exception: In an effort to ensure timely access to critical AZT therapy for at-risk newborns and to maximize patient compliance, SCDHHS allows the pharmacy or hospital provider to bill Medicaid using the mother's South Carolina Healthy Connections Medicaid card number when dispensing the initial six weeks' home supply of AZT syrup. Billing this drug to the mother's Medicaid identification number is permissible only in those instances where the newborn has not yet been assigned a South Carolina Healthy Connections Medicaid card number at the time of discharge.

The Department of Health and Environmental Control (DHEC) has recommended that the first injection of the Hepatitis B series be administered while the infant is in the hospital. The hospital reimbursement is an all-inclusive payment for services rendered during that hospital stay and thus includes the Hepatitis B vaccine.

Dates of services on or before September 30, 2015:

When billing for the administration of the Hepatitis B vaccine the appropriate procedure code is 99.55, prophylactic administration of vaccine against other diseases. Code V05.3, inoculation against Viral Hepatitis, should not be used for the administration of the Hepatitis B vaccine to infants unless it is justified by the medical condition of the infants. This diagnosis code will be disallowed unless the medical record documentation justifies its use.

For Dates of Service on or after October 1, 2015:

When billing for the administration of the Hepatitis B vaccine the appropriate procedure code is 3E0134Z, Introduction of Serum, Toxoid and Vaccine into Subcutaneous Tissue, Percutaneous Approach or 3E0234Z Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach. Administration of the Hepatitis B vaccine to infants will be disallowed unless the medical record documentation justifies its use.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Inpatient Covered Services

Accommodations

The Medicaid program sponsors semi-private or ward accommodations. A private room or other accommodations more expensive than semi-private will be allowed when such accommodations are certified as medically necessary by the attending physician or when the hospital only has private rooms. Private rooms will be considered medically necessary only when the patient's condition requires him or her to be isolated to protect his or her own health or welfare, or to protect the health and welfare of others. Patients requesting a private room or more expensive room may be billed the difference between the private/more expensive and the semi-private room rate.

Drugs

Drugs prescribed for and dispensed to an inpatient are covered and are included in the DRG payment. Those drugs furnished by a hospital to an inpatient for use outside the hospital are generally not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital and a limited supply is required until the patient can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service. Drugs furnished to a patient on discharge shall be limited to a maximum five-day supply and are covered as part of the inpatient stay.

The Hepatitis B vaccine and Respigam/Synagis® administered to an infant in the hospital are included in the hospital's DRG payment. For newborns, Medicaid will allow a six weeks' supply of zidovudine (AZT) syrup to be billed by the hospital or pharmacy provider. The AZT syrup can **only** be billed under the mother's Medicaid ID number when the newborn does not have an assigned Medicaid ID number at the time of discharge.

Supplies, Appliances, and Equipment

Items furnished by the hospital for the care and treatment of the patient during his or her inpatient stay are covered inpatient hospital services and are included in the DRG payment. Under certain circumstances, supplies, appliances, and equipment used during the inpatient stay are covered even though they are taken with the patient when he or she is discharged. These are circumstances in

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Supplies, Appliances, and Equipment (Cont'd.)

which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the items to the periods during which the individual is an inpatient. Examples of items covered under this policy include but are not limited to cardiac valves, cardiac pacemakers, and artificial limbs, which are permanently installed in or attached to the patient's body while an inpatient of the hospital.

Items such as tracheostomy tubes or drainage tubes that are temporarily installed or attached to the patient's body during inpatient treatment, are necessary to permit or facilitate the patient's release from the hospital, and are required until the patient can obtain a continuing supply, are covered as an inpatient hospital service. Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not covered as inpatient hospital services.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

Effective June 1, 2014, SCDHHS will amend the non-emergency transportation policy for self-administered oxygen dependent beneficiaries discharged from inpatient hospitals or emergency rooms. The policy applies to beneficiaries who are admitted, as an inpatient of a Hospital or Hospital Emergency Room, are oxygen dependent and currently do not have their portable oxygen system in their possession, and do not require transportation via ambulance for their return trip to their residence for any other reason. The hospital is responsible for arranging and acquiring a portable oxygen system complete with all medically necessary accessories, upon discharge. **Hospitals and Ambulance providers will no longer receive reimbursement for non-essential, non-medically necessary ambulance transportation for self-administered oxygen dependent beneficiaries.** All provider types and services are subject to post payment review by the Division of Program Integrity.

It is the responsibility of both the Hospital and DME provider to coordinate and dispense oxygen to the Medicaid beneficiary who is currently admitted to the Hospital or Hospital Emergency Room in order for the appropriate mode of non-emergent transportation to be arranged with the transportation broker upon discharge. The dispensing DME provider will be responsible for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Transportation of Self-Administered Oxygen Dependent Beneficiaries (Cont'd.)

arranging the return of the portable oxygen system dispensed by their company at the time of discharge from the admitting hospital facility.

SCDHHS will reimburse for a portable oxygen system, E0443 billed with a U1 modifier, and the dispensing DME provider will be reimbursed at a rate of $20.00 per occurrence. SCDHHS will limit the number of occurrences per patient to no more than three occurrences per calendar month. Services that exceed three occurrences per calendar month will not be reimbursed.

It is the responsibility of EMS providers whenever possible to transport oxygen dependent beneficiaries with the beneficiary's personal portable oxygen system in anticipation of the beneficiary's medical/health needs.

Services for Mental Disease

Medicaid patients admitted to a general acute care hospital for the treatment of mental disease are sponsored in the same way as patients for any other disease. Patients may be any age, and coverage is the same as for any other patient. Treatment furnished under the direction of the attending physician is covered.

Treatment for Medicaid patients in a psychiatric hospital is subject to the federal regulations regarding "institution for mental diseases" as cited in 42 CFR 441 Subpart D. Medicaid funds are available for inpatient psychiatric services rendered in a psychiatric hospital for individuals under age 21. If the beneficiary is receiving services immediately before he or she reaches 21, Medicaid will sponsor services until the beneficiary no longer requires the services or until the beneficiary reaches age 22, whichever is earlier. For further information, please call the PSC or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Depo-Provera

When revenue code 636 and J1050 are listed on an inpatient claim an add-on payment for Depo-Provera will be added to the DRG payment.

OUTPATIENT HOSPITAL SERVICES

Outpatient hospital services are diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished by or under the direction of a physician or dentist to an outpatient in an institution licensed and certified as a hospital. Outpatient services may include scheduled

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OUTPATIENT HOSPITAL SERVICE (CONT'D.)

services, surgery, observation room and board, and emergency services provided in an area meeting licensing and certification criteria.

An outpatient is a patient who is receiving professional services at a hospital for a period generally not to exceed 24 hours. An outpatient may be admitted to a room by an attending physician for either daytime or overnight observation. For additional information on observation, refer to Outpatient Observation in this section.

Outpatient Services

Medicaid outpatient hospital services are paid by a fee schedule. Outpatient services are divided into three major categories. The category and reimbursement types for outpatient services are as follows:

- Outpatient Surgical Services — Reimbursement Type 1
- Outpatient Non-Surgical Services — Reimbursement Type 5
- Treatment/Therapy/Testing Services — Reimbursement Type 4

The outpatient fee schedule is designed to reimburse for actual services rendered. Only one category of service, based on the highest classification billed, is paid per claim; however, each category can include an additional reimbursement for clinical lab services. Reimbursement is based on the fee schedule rate or the charges reflected on the claim, whichever is less. All outpatient services, with the exception of clinical lab services, will be subject to an outpatient hospital multiplier.

The fee schedule can be found in Section 4 of this manual and on the SCDHHS Web site at http://www.scdhhs.gov/.

A. Outpatient Surgical Services — Reimbursement Type 1

When an outpatient claim includes a covered CPT surgical procedure code, it will be paid as a reimbursement type 1. The total payment for reimbursement type 1 equals the rate assigned to the surgery and the established rate for clinical lab services when applicable. The surgery rate includes charges for non-clinical laboratory and radiology services, anesthesia, blood, drugs and supplies, nursing services, use of the operating room and recovery room, and all other services related to the surgery. Pre-surgical services

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

A. Outpatient Surgical Services — Reimbursement Type 1 (Cont'd.)

performed prior to the actual day of outpatient surgery must be reflected on the same bill as the surgery and should not be submitted as a separate bill.

Multiple surgical procedures will be paid at the highest surgical rate. A list of surgical procedure codes and their rates can be found on the SCDHHS Web site. Surgeries covered by Medicaid that are not on this list will be assigned a rate by SCDHHS. Diagnostic and therapeutic procedures, non-surgical CPT codes, are not reimbursed as surgeries by Medicaid and will be paid at the next appropriate reimbursement type.

The following services may be paid as add-ons to reimbursement type 1 claims:

- Observation room, revenue code 762 or 769
- Vitrasert® implant, revenue code 636 with HCPCS code J7310
- Depo-Provera®, revenue code 636 with HCPCS code J1050
- Synagis®, revenue code 636 with HCPCS code 90378
- Kyleena®, revenue code 636 with HCPCS code J7296
- Liletta®, revenue code 636 with HCPCS code J7297
- Mirena®, revenue code 636 with HCPCS code J7298
- Paragard®, revenue code 636 with HCPCS code J7300
- Skyla®, revenue code 636 with HCPCS code J7301
- Implanon®/Nexplanon®, revenue code 636 with HCPCS J7307
  Essure, revenue code 636 with HCPCS code A4264, permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure)

  This add-on service requires a Consent for Sterilization form to be signed 30 days prior to the procedure.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

B. Outpatient Non-Surgical Services — Reimbursement Type 5

An outpatient claim is classified as non-surgical, reimbursement type 5, when the claim shows an emergency room (revenue code 450), clinic visit (revenue codes 510, 511, 512, 513, 514, 515, 516, 517, 519), or treatment room (revenue code 761) without an appropriate CPT surgical procedure code present. The total payment for reimbursement type 5 equals the all-inclusive rate and the established rate for clinical lab services when applicable. The rate includes all services performed during the day of the visit except for the allowed add-ons listed below and clinical lab services. This would include patients that are sent to multiple areas of the hospital for additional services. Reimbursement type 5 with an emergency room service is paid as an all-inclusive fee determined by the level of the diagnosis, *i.e.,* non-emergent, urgent, or emergent visit. ER claims with multiple diagnosis codes will be paid at the highest level. Reimbursement type 5 with clinic services or a treatment room is paid an all-inclusive fee based on Level 1 (non-emergent) regardless of the diagnosis codes. A list of diagnosis codes by reimbursement level can be found on the SCDHHS Web site. Diagnosis codes covered by Medicaid that are not on the list will be assigned a payment level by SCDHHS.

Only one payment per day will be made for emergency room, clinic visit, and/or treatment room for the same or related diagnosis. Medical records may be requested in order to verify that the services were unrelated.

The following services may be paid as add-ons to reimbursement type 5 claims:

- Observation room, revenue code 762 or 769
- Vitrasert® implant, revenue code 636 with J7310
- Depo-Provera®, revenue code 636 with HCPCS code J1050
- Synagis®, revenue code 636 with 90378
- Implanon™, revenue code 636 with HCPCS code J7307
- Kyleena®, revenue code 636 with HCPCS code J7296

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

B. Outpatient Non-Surgical Services — Reimbursement Type 5 (Cont'd.)

- Liletta®, revenue code 636 with HCPCS code J7297
- Mirena®, revenue code 636 with HCPCS code J7298
- Paragard®, revenue code 636 with HCPCS code J7300
- Skyla®, revenue code 636 with HCPCS code J7301
- Essure, revenue code 636 with HCPCS code A4264, permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure)

  This add-on service requires a Consent for Sterilization form to be signed 30 days prior to the procedure.

C. Treatment/Therapy/ Testing (TTT) Services — Reimbursement Type 4

An outpatient claim falls into the treatment/therapy/testing (TTT) category when it does not meet either of the previous two criteria. The total payment for reimbursement type 4 services equals the rate for the revenue code or CPT code as outlined in the outpatient fee schedule and the established rate for clinical lab services when applicable.

Payment for reimbursement type 4 services is based on the revenue code or the procedure code as indicated on the fee schedule. A list of the CPT codes and the Medicaid reimbursement can be found on the SCDHHS website.

Revenue codes that do not require a CPT code may be reimbursed as an all-inclusive rate per unit of service or per date of service. Multiple revenue codes may be reimbursed per date of service. TTT services may be span billed for the same or related diagnosis.

The payment amounts for TTT services include all related non-physician services.

Outpatient Therapies

For recipients age 21 and over, physical, occupational, and speech therapies (PT/OT/ST) performed in an outpatient hospital setting must be pre-authorized by the QIO, KEPRO. At a minimum, physical therapy services must improve or restore physical functioning as well as prevent injury, impairments, functional limitations, and disability following disease, injury or loss of a body part.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Therapies (Cont'd.)

Occupational therapy must prevent, improve or restore physical and/or cognitive impairment following disease or injury. Speech language pathology must improve or restore cognitive functioning, communication skills and/or swallowing skills following congenital or acquired disease or injury.

InterQual criteria for outpatient rehabilitation will be used to support medical necessity. The list of therapy codes that requires prior authorization is listed in Section 4 of this manual. KEPRO authorizes the initial evaluation and the first four weeks of therapy upon request. At four weeks, a concurrent review is performed to re-evaluate the patient's condition and response to treatment. At that time the provider may request up to an additional eight weeks of therapy.

For claims with dates of service on or after June 1, 2012, hospital providers are required to submit the revenue code and the applicable CPT procedure code as defined in the CPT reference guide for the specified therapy. For therapy procedures defined in 15-minute sessions, SCDHHS will define 15 minutes as 1 unit of service. Therapy sessions are limited to 4 units per date of service.

Patients with Medicare as primary payor are only required to obtain a prior authorization if Medicare does not make a payment or the service is not covered by Medicare and Medicaid then becomes primary. Please note that Managed Care Organizations will continue to authorize services according to their specific plans for enrolled beneficiaries (members).

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@kepro.com

Outpatient Observation

Observation services are furnished by a hospital on its premises and include the use of a bed and periodic monitoring by a hospital's nursing or other staff. Such services must be reasonable and necessary to evaluate an outpatient's condition or to determine whether there is a need for admission as an inpatient. These services usually do not exceed one day and must be ordered verbally and/or

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Observation (Cont'd.)

authenticated by signature of a physician or another individual authorized by state licensure law and hospital bylaws to admit patients to the hospital. The period of observation begins when the physician orders observation and when the monitoring of the patient actually begins. Observation ends when ordered verbally and/or authenticated by signature of a physician or another individual authorized by state licensure law and hospital bylaws to discontinue such treatment.

The observation room revenue code (762 and 769) units **do not** multiply. Each 24 hours of observation can be filed on one claim for multiple dates of service. While observation services usually do not exceed 24 hours, they may exceed 24 hours in some cases and are not explicitly limited in duration.

Note: In cases where the observation stay must span two calendar days, to equal 24 hours, observation should not be billed for both days.

Outpatient observation charges must be billed using either revenue code 762 or 769 for up to 24 hours of continuous service. The observation period shall commence when the patient is formally admitted to an observation room. The attending physician may admit the patient for daytime or overnight observation. Observation charges may be reimbursed in addition to the surgical and non-surgical payment.

Observation days prior to an inpatient admission can be billed as outpatient services when the observation stay is unrelated to the inpatient admission, excluding the day of admission. Bill the date the beneficiary was switched from observation to inpatient status as the first day of the hospital admission. Observation stays related to and within 72 hours of an admission are considered inpatient services and are included in the inpatient DRG payment. Refer to Section 3 for specific billing instructions.

Observation should only be billed if the patient meets the conditions for observation. Do not substitute outpatient observation services for medically appropriate inpatient admissions. Test preparation, whether performed by the patient or the facility by itself, does not qualify for observation and observation should not be billed concurrently with the test. In addition, observation services

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Observation (Cont'd.)

should not automatically be billed because the time for normal recovery from a surgical procedure is exceeded. Observation would be appropriate when the recovery period exceeds normal expectations for the type of surgery and when the patient's condition requires observation.

Treatment Room

The use of a treatment room may be appropriate for procedures that do not require the resources of a surgical suite or for facilities that do not have an endoscopic suite. Treatment room charges should normally be limited to no more than two hours, and usually less. Treatment room charges are a substitute for those room charges and not an additional line item. It is not appropriate to show treatment room charges in order to augment reimbursement. Refer to Section 3 for specific billing instructions.

Pre-Admission Services (72-hour Rule)

Outpatient services rendered to a beneficiary within the three days prior to the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient diagnosis-related group (DRG). This provision applies when the outpatient services are related to the admission, *i.e.*, they are furnished in connection with the principal diagnosis that necessitates the patient's admission as an inpatient. For example, if a patient is admitted on a Wednesday, services provided by the hospital on the previous Sunday, Monday, and Tuesday are included in the inpatient DRG payment.

All outpatient services rendered on the day of an inpatient admission are included in the DRG payment regardless of diagnosis. **Pre-admission services may not be billed separately as outpatient services.**

Cancelled or Incomplete Surgery

When there are charges associated with surgery such as operating room, anesthesia, or recovery room and the surgery is incomplete or cancelled, Medicaid can be billed. Refer to "Modifiers on Outpatient Surgery Claims" in Section 3 for billing instructions.

Specimen Collection Fees

Specimen collection fees are not billable to Medicaid as a separate line item. Specimen collection fees are considered part of the specimen test.

Immunizations

Immunizations are compensable as part of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Drugs

Drugs administered to patients during outpatient treatment are not separately reimbursed. The reimbursement for drugs and biologicals is included in the all-inclusive outpatient payment with the exception of the add-ons: Depo-Provera®, Vitrasert®, and Synagis®.

Self-Administered Drugs

Self-administered drugs (SADs) given in an outpatient setting are not separately reimbursed by SCDHHS. Payment for SADs is instead included in the all-inclusive outpatient reimbursement, to include dually eligible beneficiaries.

Two factors are used in determining whether a drug should be considered self-administered:

- The usual method of administering the drug
- The form of the drug (*i.e.*, oral, injected, etc.)

For example, oral medications provided to patients in an outpatient setting are considered SADs since such drugs are usually self-administered.
As a further illustration, according to these guidelines, insulin is excluded from coverage unless administered to the patient in an emergency situation (*e.g.*, diabetic coma), in which case the SAD is covered in the all-inclusive emergency room reimbursement.

Clinical Lab Services

In order to comply with Title XIX of the Social Security Act, Section 1903(i)(7), Medicaid reimbursement for clinical lab services must not exceed the rates established by Medicare.

Rates for clinical lab procedures, as identified by CMS, will be updated yearly based on the Medicare Fee Schedule rates. The Medicaid Management Information Systems will identify Clinical Lab Panels and Individual Automated Tests and reimburse the amount based on the Automated Test Panel (ATP) pricing schedule. Clinical lab panels will only reimburse one unit per date of service. Claims with multiple units of the same clinical lab panel on the same date of service will be rejected.

For clinical laboratory tests, if a panel is requested, the professional judgment of the physician must dictate the medical necessity of the complete panel instead of an individual test. Likewise, individual tests ordered by a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Clinical Lab Services (Cont'd.)

physician must indicate a medical reason for the individual test in lieu of a panel that is less expensive. All the tests in the definition of a panel must be performed for the provider to use that panel's CPT codes. The physician should review what tests are in the panels and not order individual tests that might duplicate tests.

Laboratory Tests, EKGs, and X-rays

Laboratory tests, EKGs, and x-rays are covered under Medicaid if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. The physician must specify the actual tests to be performed.

Laboratory tests, EKGs, x-rays, and similar ancillary services must be medically justified as a necessary part of the patient's care. To justify the use of many special tests where the final diagnosis is uncomplicated, the record must substantiate why a more complicated test was considered. The requirements for ancillary tests must be indicated and authenticated by signature of the physician. The results of the ancillary testing must be entered into the patient's record.

Note: SCDHHS will allow a hospital to bill for services performed at another laboratory, provided that the following requirements are met: (1) the hospital and the laboratory must have a written agreement that the laboratory will look solely to the hospital for reimbursement and will not independently bill S.C. Medicaid for these services; (2) the arrangement will result in no additional cost to the S.C. Medicaid program (*e.g.,* no "mark-up" by the hospital, no administrative fees, no handling charges, etc.); and (3) the hospital should bill the charge which is submitted to all other payers. SCDHHS should not receive two bills for the same service and SCDHHS should not incur any additional expenses as the result of this practice.

Depo-Provera®, Vitrasert®, Synagis®, and Implanon®

Depo-Provera® may be billed in addition to a clinic visit when family counseling is provided or separately under the TTT category. Vitrasert® may be billed in addition to a surgical claim. Implanon™ is a single-rod implantable contraceptive that is effective for up to three years. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Depo-Provera®, Vitrasert®, Synagis®, and Implanon® (Cont'd.)

These codes must be billed using revenue code 636 and the following HCPCS codes:

- Depo-Provera®, HCPCS code J1050
- Vitrasert®, HCPCS code J7310
- Synagis®, HCPCS code 90378
- Implanon®, HCPCS code J7307

Long Acting Reversible Contraceptives (LARCs)

Long Acting Reversible Contraceptives (LARCs) provided in an Inpatient Hospital setting are considered an add-on benefit to the Diagnostic Related Group (DRG) reimbursement. SCDHHS will reimburse providers for LARCs through a gross level credit adjustment. In order to process the LARC payment, hospitals are required to utilize the Healthcare Common Procedure Coding System (HCPCS) code that represents the device, along with the appropriate ICD-PCS Surgical Code and the ICD-CM Diagnosis Code that best describe the services delivered. The LARC reimbursement will process as a gross level credit adjustment and will appear on a future remittance advice. Providers will receive a letter of notice and reconciliation report quarterly identifying the credit adjustment along with pertinent patient information to apply the credit to the correct patient account. The letter of notice will identify the Adjustment Reference Number and will be identified by the prefix LARC.

Covered LARCs:

- Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg
- Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg
- Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg
- Intrauterine (IU) copper contraceptive (Paragard®)
- Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg
- Etonogestrel (contraceptive) implant system, including implant and supplies (Implanon®/ Nexplanon®)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Long Acting Reversible Contraceptives (LARCs) (Cont'd.)

- Permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure). This requires a sterilization request form to be signed thirty days prior to the procedure

Physician Services

The physician component (services for direct patient care) for outpatient services must be billed separately on a Health Insurance Claim (CMS-1500) form. **Payment is based on the physician's Medicaid fee schedule**. All hospital-based physician services not included in the outpatient fee schedule may be billed under the hospital-based physician or group number assigned to the hospital, except hospital-based neonatologists and anesthesiologists, who must bill under their individual provider numbers. Please refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual for specific policy and billing requirements.

When a physician establishes an office within a hospital or other institution, reimbursement for services and supplies furnished in the office must be determined in accordance with the "incident to a physician's professional service" criteria as outlined by federal regulation.

A distinction must be made between the physician's office and the institution of which the physician is the administrator or owner. For services to be covered, the auxiliary medical personnel must be members of the office staff rather than the institution's staff, and the cost of supplies must represent an expense of the physician's office practice.

Outpatient Medical Records

When a patient is seen on repeat outpatient visits, the patient's record must show that the supervising physician is keeping abreast of the patient's progress and need for continuing care. If the patient's condition warrants more than one visit per month, the record must reflect a specific plan of care that justifies the need for these visits. Outpatient medical records must also meet the standards outlined in Section 1 of this manual and in Medical Record and Documentation Requirements in this section.

Outpatient Fee Schedule

The outpatient fee schedule can be found in Section 4 of this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

ADULT NUTRITIONAL COUNSELING

Effective August 1, 2015, SCDHHS will implement the Obesity initiative. This policy currently targets those obese individuals who do not meet the criteria for bariatric surgery or related services. Obesity is defined for this program as an adult patient with a body mass index (BMI) of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women
- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating physician, are not eligible to participate in the obesity program
- Beneficiaries who have had or scheduled to have bariatric surgery
- Beneficiaries actively being treated with bariatric surgery

There is an exhaustive list of medications that could contribute to obesity. Here are examples of medications that may cause weight gain:

- Atypical antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
- Long-term use of oral corticosteroids (prednisone, prednisolone)
- Certain anticonvulsant medications (valproic acid, carbamazepine)
- Tricyclic antidepressants (amitriptyline)

Note: For Healthy Connections Medicaid members who receive Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

The program consists of intensive behavioral therapy for obesity and includes three factors:

- Screening for obesity in adults using measurement of BMI calculated by dividing the patient's weight in kilograms by the square of height in meters
- Dietary (nutritional) assessment
-

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

ADULT NUTRITIONAL COUNSELING (CONT'D.)

- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise

All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The following billing instructions apply to Fee for Service only. For instructions for submitting claims to Managed Care Organizations (MCOs), please refer to the provider contract with the appropriate MCO.

Hospitals will not be reimbursed separately for the physicians or dietitian services on an UB-04 claim form. Hospitals may enroll dietitians with their professional clinics and bill for their dietitian's services on the CMS-1500 form. Please note that the appropriate revenue code for hospitals to bill for Obesity Services is **942 Other Therapeutic Services – Education and Training,** which is not a covered service with SCDHHS. Therefore, it is imperative that hospitals link the licensed dietitians to their professional clinic group for payment of services.

CHILDREN'S NUTRITIONAL COUNSELING

All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Hospitals will not be reimbursed separately for the physicians or dietitian services on an UB-04 claim form. Hospitals may enroll dietitians with their professional clinics and bill for their dietitian's services on the CMS-1500 form. Please note that the appropriate revenue code for hospitals to bill for Obesity Services is **942 Other Therapeutic Services – Education and Training** which is not a covered service with SCDHHS. Therefore, it is imperative that hospitals link the licensed dietitians to their professional clinic group for payment of services.

Please refer to the Physicians Laboratories and Other Medical Professionals Manual for the complete obesity policy (adults and children) for providers and dietitians.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PROFESSIONAL SERVICES

The following professional services may be rendered in a hospital inpatient, outpatient, or clinic setting. Guidelines for coverage and reimbursement can be found in the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual. Services rendered must be billed on a CMS-1500 claim form.

Hospital-Salaried/Hospital-Based Physician

A hospital-salaried or hospital-based physician is a physician licensed to practice medicine or osteopathy. This individual is employed by a hospital; payment for the physician's services is claimed by the hospital as an allowable cost under the Medicaid program and billed by the contracted hospital.

Physician's Assistant

A physician's assistant is a health professional who performs such tasks as are approved by the State Board of Medical Examiners in the state where he or she renders services in a dependent relationship with his or her supervising physician and under personal supervision as defined in the Direct Physician Supervision section of the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual. Medicaid reimbursement will be made to the supervising physician, clinic, or hospital where the professional is employed and where the service is rendered under the criteria in the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual.

Certified Registered Nurse Anesthetist/Anesthetist Assistant

A Certified Registered Nurse Anesthetist (CRNA) or Anesthetist Assistant (AA) must be licensed to practice as a registered nurse and CRNA/AA in the state where he or she is rendering services. CRNAs may work independently or under the supervision of an anesthesiologist. AAs may only work under the supervision of an anesthesiologist. CRNA services rendered by a hospital-based CRNA may be billed under the hospital-based physician's number assigned to that hospital. However, each CRNA must be enrolled in the Medicaid program and his or her individual CRNA provider number must appear on the CMS-1500 claim form.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Certified Nurse Midwife

A Certified Nurse Midwife (CNM) must be licensed to practice as a registered nurse and as a certified nurse midwife in the state where he or she is rendering services. The CNM practices under the supervision of a physician preceptor according to mutually agreed-upon protocol. CNM services may be reimbursed under the midwife's Medicaid provider number or the supervising physician's Medicaid number.

Nurse Practitioner/Clinical Nurse Specialist

A Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) has completed an advanced formal education program and has been certified by the State Board of Nursing as a nurse practitioner or clinical nurse specialist. The NP/CNS practices under a physician preceptor according to mutually agreed-upon protocol. The NP/CNS may be reimbursed under their individual Medicaid provider number or the supervising physician's Medicaid number.

Supervision

For Medicaid professional billing purposes, direct supervision means that the teaching physician is accessible as defined in Subsection I, and the teaching physician is responsible for **all** services rendered, fees charged, and reimbursement received.

Teaching Physician Policy

When interns or residents provide service, the following definitions apply:

- Resident — A resident is either an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.
- Medical Student — A medical student is an individual who is enrolled in a program culminating in a degree in medicine. Any contribution of a medical student to the performance of a billable service or procedure must be performed in the physical presence of a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Teaching Physician Policy (Cont'd.)

teaching physician or jointly with a resident in a service meeting the requirements set forth for teaching physician billing.

- Teaching Physician — A teaching physician is an individual who, while functioning under the authority and responsibility of a residence program director, involves residents and/or medical students in the care of his or her patients or supervises residents in caring for patients.

Services provided by residents under the direct supervision of a teaching physician are billable to Medicaid. For Medicaid professional component billing purposes, direct supervision means that the teaching physician is accessible, as defined in Subsection I, when the services being billed are provided by the resident. The teaching physician is responsible for all services rendered, fees charged, and reimbursements received. The services must be documented, as defined in Subsection II, in the patient's medical record. The supervising physician must sign the patient's medical record indicating that he or she accepts responsibility for the services rendered.

Subsection I

Accessibility of the teaching physician while the resident is providing services is defined as follows:

- Ambulatory — Accessibility of the teaching physician for supervision of ambulatory services requires the teaching physician to be present in the clinic or office setting while the resident is treating patients. The physician is thus immediately available to review the patient's history, personally examine the patient as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.
- Inpatient — Accessibility of the teaching physician for supervision of non-procedural inpatient services requires that the teaching physician evaluate the patient within 24 hours of admission and on each day thereafter for which services are billed. The teaching physician must review the patient's history, personally examine the patient as

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Subsection I (Cont'd.)

needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

- Procedures
  - Minor Procedures—For supervision of procedures that take only a few minutes to complete or involve relatively little decision-making once the need for the procedure is determined, the definition of accessibility requires that the teaching physician be on the premises and immediately available to provide services during the entire procedure.
  - All Other Procedures–Accessibility for supervision of all other procedures requires that the teaching physician be physically present during all critical and key portions of the procedure and be immediately available to provide services during the entire procedure.

Subsection II

Documentation for services must include a description of the presence and participation of the teaching physician. The resident may document the encounter to include a note describing the involvement of the teaching physician. The teaching physician's signature is then adequate to confirm agreement. Documentation of an encounter by the teaching physician may make reference to portions of a medical student's notes. The combined entries of the medical student, resident, and teaching physician must be adequate to substantiate the level of service required and billed. Documentation must include the teaching physician's signature for each encounter that will be billed as a professional charge.

Note: A hospital may bill Medicaid a clinic visit (facility charge) for patients seen by a resident even though the encounter has not been signed by the teaching physician.

NON-COVERED SERVICES

Convenience Items

Items provided for the convenience or comfort of the patient at his or her request is non-covered. Non-covered charges include but are not limited to the difference

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Convenience Items Cont'd.)

between a private and semi-private room when requested by the patient and not medically necessary. Items routinely covered in room rates must be offered to Medicaid patients under the same conditions as non-Medicaid patients.

Incidental Procedures

Incidental procedures are performed at the same time as major surgery in anticipation of possible future problems. Examples include but are not limited to incidental appendectomies, incidental scar excisions, simple lysis of adhesions, puncture of ovarian cysts, and simple repair of hiatal hernias. No reimbursement will be made for subsequent procedures that do not add significantly to the complexity of the major surgery or are rendered incidentally and performed at the same time as the major surgery. Incidental procedures should not be shown on the claim.

Cosmetic Procedures

Cosmetic surgery or expenses incurred in connection with such services are non-covered under Medicaid. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (*i.e.*, as soon as medically feasible) repair of accidental injury **or** for the improvement of the functioning of a malformed body part. This does not apply to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

Repair of the following birth defects is not considered cosmetic surgery: cleft lip, cleft palate, webbed fingers and toes, congenital ptosis, and other birth defects that impair bodily function.

Experimental/ Investigational Procedures

Procedures that are experimental/investigational are non-covered. Procedures that are performed in only a few medical centers across the United States are considered part of this group.

Partial Hospitalization

Partial hospitalization rendered in an outpatient hospital setting is non-covered by Medicaid. Partial hospitalization is a comprehensive, structured program that uses a multidisciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Infertility Procedures

Any medications, tests, services, or procedures performed for the diagnosis or treatment of infertility are non-covered. Codes related to hystosalpingographs (58345 and 74742) are non-covered by Medicaid.

Hospital Acquired Conditions (HACs), Other Provider Preventable Conditions (OPPCs), and Never Events (NEs)

Effective for dates of service October 1, 2011, and thereafter; Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPCs).

Provider Preventable Conditions are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs) or Never Events (NEs).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs). Other Provider Preventable Conditions refer to OPPCs and Never Events (surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient, etc.).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment(s) may be limited to the extent that the identified PPCs would otherwise result in an increase in payment(s).

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries. The Medicaid participant should never be billed for these events.

By definition, PPCs must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospital Acquired Conditions (HACs), Other Provider Preventable Conditions (OPPCs), and Never Events (NEs) (Cont'd.)

- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought, and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate elements of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Inpatient Acute Care Hospitals, Ambulatory Surgery Centers (ASCs), Physicians and Other Practitioners are held accountable for Never Events (NEs) while Inpatient Acute Care Hospitals are also held accountable for Hospital Acquired Conditions (HACs) and Other Provider Preventable Conditions (OPPCs).

The non-payment policy includes the following Never Events and OPPCs:

Never Events:

- Surgery on a wrong body part or site
- Wrong surgery on a patient
- Surgery on the wrong patient

OPPCs:

- Post-operative death in normal healthy patient
- Death/disability associated with use of contaminated drugs, devices or biologics
- Death/disability associated with use of device other than as intended

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospital Acquired Conditions (HACs), Other Provider Preventable Conditions (OPPCs), and Never Events (NEs) (Cont'd.)

- Death/disability associated to medication error
- Maternal death/disability with low risk delivery
- Death/disability associated with hypoglycemia
- Death/disability associated with hyperbilirubinemia in neonates
- Death/disability due to wrong oxygen or gas

For dates of service on or before **September 30, 2015**, providers should review the FY 2014 Final CMS HAC List on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2013_Final_HACsCodeList.pdf.

For dates of service on or after October 1, 2015, providers should view the appropriate ICD-10 HAC list on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html.

The APR-DRG software will identify diagnoses that meet the definition of a HAC, OPPC, or NE. The grouper software will then ignore the HAC, OPPC, or NE and assign a DRG as if it were not present. The proposed regulation also extends the non-payment policy to Medicaid contracts. Therefore, the Managed Care plans will not be required to pay for HACs, OPPCs, and NEs.

As referenced earlier in the policy, no reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider (Present on Admission).

OUT-OF-STATE SERVICES

Treatment Rendered Outside of the S.C. Medical Service Area

The term South Carolina Medical Service Area (SCMSA) refers to the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border. Charlotte, Augusta, and Savannah are considered within the service area. Services provided to Medicare/Medicaid beneficiaries in the SCMSA do not require prior approval from Medicaid. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Treatment Rendered Outside of the S.C. Medical Service Area (Cont'd.)

The South Carolina Medicaid program will compensate medical providers outside the SCMSA in the following situations:

- When a beneficiary traveling outside the SCMSA needs emergency medical services and the beneficiary's health would be endangered if necessary care were postponed until his or her return to South Carolina. Emergency medical services are determined by the diagnosis codes listed on the claim, and medical review.
- Out-of-state referrals by physicians when needed services are not available within the SCMSA
- All pregnancy-related services, including delivery

Out-of-state hospital services are limited to true emergencies or those services for which prior approval from SCDHHS has been obtained. A true emergency is described as an accident or disease in which the health of the beneficiary would be endangered if necessary care and services were postponed until return travel to South Carolina.

Out-of-State Hospitals

In order to participate in the Medicaid program, an out-of-state hospital must enroll with South Carolina Medicaid by completing a provider enrollment package. By signing the provider enrollment forms, the provider agrees to payment at the South Carolina rate of reimbursement and to comply with all federal and state laws and regulations. Claims and all needed information must be submitted within one year from the date of service or date of discharge for inpatient claims or reimbursement will be denied.

Out-of-state hospital claims should be sent in hard copy to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

For assistance with out-of-state hospital claims, please contact the PSC at 1-888-289-0709 or submit an online inquiry at http:www.scdhhs.gov/contact us.

For policies regarding organ transplants, please refer to Organ Transplants in this section.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Out-of-State Referrals by Physicians When Needed Services Are Not Available Within the SCMSA

In all but emergency situations, approval should be requested prior to the out-of-state service. For out-of-state referrals, the South Carolina referring physician must contact the Physician Services via the PSC at 1-888-289-0709, an online inquiry at http://www.scdhhs.gov/contact-us, or by fax at (803) 255-8255 to obtain prior approval. Written requests should be submitted to:

SCDHHS
Division of Physician Services
Attn: Out-of-State Coordinator
Post Office Box 8206
Columbia, SC 29202-8206

The written request must include all of the following information:

- Beneficiary's name and Medicaid number
- Date of service (state as "tentative" if unscheduled at the time of request)
- Diagnosis (past and current history if pertinent to show medical necessity)
- An explanation as to why the physician believes these services must be rendered out-of-state instead of within the SCMSA
- Name, address, and telephone number of the out-of-state provider(s) who will render the medical services (for example, hospital and physician(s) involved in that patient's medical treatment)
- Identification of any services that are considered experimental and/or investigational, sponsored under a research program, or performed in only a few medical centers across the United States

Transportation may be provided to Medicaid patients who are referred out-of-state, as well as to the patient's escort, when necessary. Transportation and other assistance are only provided when there are no other means available to the patient to meet the needs connected with out-of-state travel. Adequate advance notice as well as prior approval is mandatory in order to make the necessary travel arrangements. Once the out of state referral is approved, the provider should notify the beneficiary that if transportation is needed, the beneficiary should contact the SCDHHS transportation broker in his or her region.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Out-of-State Referrals by Physicians When Needed Services Are Not Available Within the SCMSA (Cont'd.)

Note: Medicaid will accept and review for medical necessity any out-of-state claims from medical providers who did not seek approval before filing the claim. However, experience has shown that these providers put themselves under an otherwise avoidable risk of non-payment or delayed payment due to the lack of knowledge of S.C. Medicaid claim filing policies and procedures.

Foster Children Residing Out of the SCMSA

The Department of Social Services (DSS) will be responsible for all Medicaid-eligible foster children when they reside out-of-state. The SCDHHS county case manager assigned to the case should assist with medical services.

Prior approval is not required for services rendered to foster children who live out-of-state; however, medical necessity remains a requirement. The out-of-state coordinator should be contacted via the PSC at 1-888-289-0709 or by submitting an online inquire at http://www.scdhhs.gov/contact-us for two reasons:

- The coordinator must determine whether the medical services can be reimbursed through the Medicaid program or whether DSS will reimburse the medical provider.
- If Medicaid can reimburse for the services, proper enrollment and billing information needs to be sent to the medical providers involved.

Ancillary and Other Out-of-State Services

Other health care services are compensable under the S.C. Medicaid Out-of-State Program. For specific out-of-state referrals, please contact the PSC or submit an online inquiry.

SPECIAL COVERAGE ISSUES

Administrative Days

The Department of Health and Human Services sponsors administrative days for Medicaid-eligible patients (regardless of age) who no longer require acute hospital care but are in need of nursing home placement that is not available at that time. Medicaid sponsors administrative days in any South Carolina acute care hospital contracted within the South Carolina service area. The patient must

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Administrative Days (Cont'd.)

meet either Medicaid intermediate or skilled level-of-care criteria.

Coverage for administrative days may begin with the day of discharge from acute care. It is not necessary to allow for patient grace days. Medicaid coverage terminates once a nursing home bed becomes available within the South Carolina service area. Should the patient or family refuse to accept the bed, the patient is then responsible for charges incurred for any remaining days.

Dually eligible beneficiaries (Medicare/Medicaid) may be eligible for administrative days if they are below Medicare's skilled level of care or have exhausted their Medicare benefits. If the beneficiary is below Medicare's skilled level of care, the initial claim must include a copy of the Hospital Issued Notice of Non-Coverage (HINN) letter. If the Medicare benefits are exhausted, a statement from a representative of the hospital indicating the date benefits were exhausted must accompany the initial bill. If available, Medicare lifetime reserve days must be exhausted before administrative days can be approved.

Swing bed hospitals may furnish administrative days only when all swing beds in the hospital are occupied.

Level of Care Determination

Community Long Term Care (CLTC) is responsible for assessing administrative days beneficiaries to determine if the beneficiary meets the intermediate or skilled Medicaid level of care criteria. A Long Term Care Assessment Form (DHHS Form 1718) will be completed. CLTC will determine a level of care or tentative level of care. The tentative level of care is reserved for those beneficiaries who are expected to be admitted to a nursing facility within 14 days. Level-of-care determinations will be documented on either a Level of Care Certification Letter (DHHS Form 185) or Community Long Term Care Notification Form (DHHS Form 171). Either of these forms can be used when billing administrative days.

Once a certification letter is issued, CLTC will close the case. It will be the responsibility of the hospital staff to assure that the client continues to meet the level-of-care criteria. If the beneficiary goes from administrative days to acute care and back to administrative days within the same hospital stay, a new certification letter or notification form does not have to be completed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Level of Care Determination (Cont'd.)

Before an administrative days beneficiary transfers to a nursing home, the hospital discharge planner must contact CLTC and request that the client's case be reopened. CLTC will reprocess the case to ensure that the client continues to meet the level of care criteria for Medicaid-sponsored nursing home care. A certification letter will be sent to the nursing home upon the client's discharge.

Note: Do not contact CLTC when a beneficiary enters a nursing home as Medicare-skilled. In these cases, certification letters do not apply and will not be issued. CLTC must be notified when a beneficiary is transferred to another hospital for administrative days coverage.

If the beneficiary has been discharged from the hospital and was seen by CLTC while in the hospital, administrative days can be billed using either the Notification Form (DHHS Form 171) issued with the tentative level of care or a Certification Letter (DHHS Form 185) which may have been issued based on the status of the beneficiary when seen by CLTC.

Retroactive Certification

In cases of retroactive Medicaid or where a dually eligible beneficiary has been denied or has exhausted Medicare benefits, the CLTC area office may complete a certification retroactive to the date of admission to the Administrative Days program or the date Medicare benefits were exhausted. The Certification Letter (DHHS Form 185) will be issued based on current conditions. If the beneficiary does not appear to meet level-of-care criteria at present but appeared to meet level-of-care criteria for the date of request based on the medical records, CLTC will put an end date on the Certification Letter. Support documentation such as copies of the medical record or any correspondence from Medicare may be requested from the hospital to ensure the patient met the level-of-care criteria for the period for which Medicaid coverage is being requested.

If the beneficiary has been discharged from the hospital and was never seen by CLTC, the hospital should contact the Administrative Days program representative. The hospital will be asked to send the beneficiary's discharge summary and physician's progress notes from the inpatient admission for review. SCDHHS staff will then determine if the beneficiary is eligible for administrative days.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospital-Issued Notification Letters

When the hospital UR committee determines that acute care is no longer necessary, the hospital should issue to the patient a Notification of Administrative Days letter. When a nursing home bed becomes available, issue the Notice of Termination of Administrative Days letter. The hospital has the option of giving a three-day grace period if the patient needs time to arrange for the transfer. The Notice of Termination of Administrative Days should be included in the patient's record and be available to SCDHHS if requested. The patient has the right to appeal the termination of administrative days. Refer to Utilization Review Services in this section.

Dually Eligible Beneficiaries

Dually eligible beneficiaries who fall below Medicare's skilled level of care or have exhausted their Medicare benefits may be eligible for administrative days. If the beneficiary is below Medicare's skilled level of care, the initial claim must include a copy of the HINN letter. If the Medicare benefits are exhausted, a statement from a representative of the hospital indicating the date benefits were exhausted must accompany the initial bill. If available, Medicare lifetime reserve days must be exhausted before administrative days can be approved. If Medicare grace days are provided, administrative days cannot be billed for these days.

Medical Record Requirements

A discharge summary must be completed when a patient is discharged from acute care. If during the administrative days period the condition of the patient changes to acute, a new admission is warranted. However, an admitting history/physical and discharge summary must be completed for each acute care stay. Should a hospital wish to use one medical record for both the acute and administrative days stay, an "interim type" discharge summary outlining the acute stay must be included in the patient's file.

If the beneficiary goes from administrative days to acute care and back to administrative days within the same hospital stay, a new Certification Letter or Notification Form does not have to be completed. However, the beneficiary must meet the Medicaid skilled or intermediate level of care criteria for each administrative days period.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes

When acute care is terminated, the hospital should administratively discharge the patient and bill Medicaid as usual. Administrative days should not be billed in cases under QIO reconsideration until the final QIO determination has been issued.

It is recommended that administrative days claims be filed monthly. Bill revenue code 100 (all-inclusive fee) to reflect all charges applicable to administrative days. Reimbursement for administrative days is an all-inclusive per diem rate depending upon the level of care; it includes drugs and supplies. Administrative days may be billed as routine or ventilator-dependent. Ancillary services rendered to patients in administrative days may be billed under the hospital outpatient provider number and will be reimbursed according to the outpatient fee schedule.

The following documentation must be sent to SCDHHS with the initial claim for administrative days:

- CLTC Level of Care Certification Letter (DHHS Form 185) or CLTC Notification Letter (DHHS Form 171)
- Notification of Administrative Days Coverage letter
- A signed statement that a nursing home bed was not available
- Medicare's HINN (when appropriate)

Subsequent administrative days claims must be submitted with a dated statement indicating the unavailability of a nursing home bed on a monthly basis. Documentation to support a weekly nursing home bed search should be kept in the patient's medical record or on another form.

All claims for administrative days must be submitted in hard copy to:

SCDHHS
Division of Hospital Services
Attn: Administrative Days Program Representative
Post Office Box 8206
Columbia, SC 29202-8206

Note: Administrative days claims are subject to all third party regulations and will reject if the patient has skilled nursing coverage.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes (Cont'd.)

Administrative days claims must meet the Medicaid policy on time limits for submitting claims. Please refer to Section 1 for this information. An exception to this policy is retroactive eligibility.

For retroactive eligibility, administrative days claims must be received within six months of the beneficiary's eligibility determination. The claim must be one that can be processed without additional information from the provider or from another third party, and must be error free. Claims must be submitted in hard copy form with a note attached explaining that the case involves retroactive eligibility.

You are encouraged to call your provider representative for assistance on problem claims to make certain you are reimbursed for all services within the time limit. Please refer to Section 3 of this manual for specific billing instructions.

Physician Services

Physicians who are treating patients in administrative days can bill for services rendered using the same procedure codes that they use for their patients in nursing homes and rest-home facilities. Providers should reference the Current Procedural Terminology manual for the applicable CPT codes.

The specific code used will depend on whether the patient is new or established and on the level of care given. Physician services must be billed on the CMS-1500 claim form using place of service 21.

One limited examination per 30 days is required for all administrative days patients. Visits must be medically necessary. Additional visits may be allowed if medical justification is submitted. Please refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual for billing instructions.

Organ Transplants

Medicaid coverage of transplant services falls into two groups. Group I includes corneal and kidney transplants. Group II includes matched bone marrow, mismatched bone marrow, pancreas, heart, liver, small bowel, liver/small bowel, liver/pancreas, liver/kidney, kidney/pancreas, lung, heart/lung and multivisceral.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Group I

Corneal and Kidney

Corneal and kidney transplants do not require prior authorization. SCDHHS will establish a quarterly post payment review process for Kidney transplants to monitor utilization and other policy guidelines. All claims are subject to review by the agency's Division of Program Integrity.

Group II

Matched Bone Marrow, Mismatched Bone Marrow, Pancreas, Heart, Liver, Small Bowel, Liver/Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/ Pancreas, Lung, Heart/Lung and Multivisceral

Matched bone marrow (autologous inpatient and outpatient, allogeneic related and unrelated, and cord) transplants do not require prior authorization. SCDHHS will establish a quarterly post payment review process for matched bone marrow transplants to monitor utilization and other policy guidelines. All claims are subject to review by the agency's Division of Program Integrity.

All other potential transplants, cadaver or living donor, must be authorized by the QIO, KEPRO, before the services are performed. SCDHHS will only support the referral of patients for an evaluation to Centers for Medicare and Medicaid Services (CMS) certified transplant centers. This will include certified facilities that are contracted with SCDHHS as well as certified facilities that are located outside of the South Carolina medical service area (> 25 miles of South Carolina borders). For a complete list of CMS approved centers, visit the CMS Web site at:

http://www.cms.hhs.gov/ApprovedTransplant Centers

Referral requests for organ transplants to both in-state and out-of-state centers must be submitted to the QIO, KEPRO, before the services are rendered. The requests should include the Transplant Prior Authorization Request Form, a letter from the attending physician that describes the type of transplant needed, the patient's current medical status, course of treatment, and the name of the center to which the patient is being referred. Upon approval, KEPRO will issue an approval letter. The approval letter will serve as authorization for pre-transplant services (72 hours pre-admission), the transplant event (hospital

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Group II (Cont'd.)

admission through discharge), and post-transplant services up to 90 days from the date of discharge. The letter will also contain an authorization number that must be entered in the prior authorization field of all UB-04 and the CMS-1500 claim forms submitted for reimbursement.

Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods.

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@kepro.com

Once the authorization letter is received, the provider should notify the beneficiary that if transportation is needed, the beneficiary should contact the SCDHHS transportation broker in his or her region.

Hysterectomy

Medicaid requires pre-admission surgical justification for hysterectomies by KEPRO. Prior authorization must be obtained even if the surgery follows a delivery. Providers should use the Request for Surgical Justification for Hysterectomy Form and the Consent for Sterilization Form with each request. There is a 30 day wait period from the date the Consent form is signed before the surgery is performed. InterQual criteria will be used for screening prior authorization requests. For urgent and emergent hysterectomy cases the 30 day wait is not required, however the reason for the emergency must be provided by the physician. The claim will be reviewed retrospectively.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods.

KEPRO Customer Service:	1-855-326-5219
KEPRO Fax:	1-855-300-0082
For Provider Issues email:	atrezzoissues@kepro.com

A hysterectomy must be medically necessary and meet the following requirements:

- The beneficiary or her representative, if any, must be informed orally and in writing that the hysterectomy will render the beneficiary permanently incapable of reproducing.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hysterectomy (Cont'd.)

- The beneficiary or her representative, if any, must sign and date the Consent for Sterilization Form, DHHS 687, prior to the hysterectomy.

The Consent for Sterilization Form is acceptable when signed after the surgery only if it clearly states that the patient was informed before the surgery that she would be rendered incapable of reproduction.

The Consent for Sterilization Form is not required if the individual was already sterile before the surgery or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency.

Reimbursement for a hysterectomy is not available if the hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy may not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

Retroactive Eligibility

A hysterectomy is reimbursed by Medicaid in cases of retroactive eligibility only if the physician certifies one of the following in writing:

- The individual was informed before the surgery that the hysterectomy would make her permanently incapable of reproducing.
- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was sterile at the time of the hysterectomy. The certification must state the cause of the sterility.
- The individual required a hysterectomy because of a life-threatening emergency situation and the physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening situation in which the physician determined that prior acknowledgement was not possible. The certification must include a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Retroactive Eligibility (Cont'd.)

diagnosis and description of the nature of the emergency.

Elective Sterilization

SCDHHS is required to have a completed DHHS Form 687 (Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients, March 1997 edition) for all elective sterilizations. Sterilization claims and consent forms are reviewed for compliance with Federal Regulation 441.250 – 441.259. It is the physician's responsibility to obtain the consent and submit this form to SCDHHS. Photocopies are accepted if legible.

Definitions

The following definitions are from the Code of Federal Regulations, Section 441.250-441.259:

1. Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual, male or female, permanently incapable of reproducing.
2. Institutionalized individual means an individual who is (a) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or (b) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
3. Mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Sterilization Requirements

For Medicaid financial coverage of an elective sterilization for male or female, the following requirements must be met:

1. The individual must be 21 years old at the time the consent form is signed.
2. The individual cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization Requirements (Cont'd.)

should call the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us with their concerns.

3. The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. A witness of the patient's choice may be present during the consent interview.
4. A copy of the consent form must be given to the patient after Parts I, II, and III are completed.
5. At least 30 days, but no more than 180 days, must have passed between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (*e.g.*, day one begins the day after the signature). Only the beneficiary may sign Part I of the consent form.
6. Exceptions to the 30-day waiting period are:
   a) Emergency abdominal surgery. The emergency does not include an operation to sterilize the patient. At least 72 hours must have elapsed since the informed consent to sterilize was given. An explanation must accompany the claim.
   b) Premature delivery. The sterilization consent must have been signed at least 30 days before the expected date of delivery. In cases involving a Cesarean section, the scheduled date of the Cesarean is considered the expected date of delivery. For premature deliveries, at least 72 hours must have elapsed since the informed consent to sterilize was given.

Informed consent may not be obtained while the individual to be sterilized is:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substances which may affect the patient's judgment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization Requirements (Cont'd.)

Although hospitals are not required to submit a sterilization consent form with their claim, payment will be recouped if no such documentation is present in SCDHHS records or if the documentation is inaccurate. Hospital providers will be notified in writing and given 30 days to submit the consent form before a recoupment is made.

Sterilization Consent Form Requirements

All sections of the Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients form (DHHS Form 687) must be completed. Consent forms are correctable, except for the beneficiary's signature and date. A consent form, along with instructions for its completion, can be found in the Forms section of this manual.

Abortions

Non-Elective Abortions

All non-elective abortions including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record show such a diagnosis. If unable to determine whether the patient was in the process of an abortion from the hospital records, SCDHHS will ask the hospital to obtain additional physician's office or clinic notes and/or ultrasound reports. Medical procedures necessary to care for a patient with ectopic pregnancy are not modified by this section and are compensable services.

Therapeutic Abortions

SCDHHS requires documentation for all claims submitted for therapeutic abortions. This includes claims for the attending physician, the anesthesiologist, the hospital, etc.

Pursuant to 42 CFR 441.203 and 441.206, therapeutic abortions are sponsored only in cases that a physician has found and certified in writing to the Medicaid agency that, on the basis of his or her professional judgment, the pregnancy is the result of an act of rape or incest, or the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

The Abortion Statement is required and must contain the name and address of the patient, the reason for the abortion, and the physician's signature and date. The patient's certification statement is only required in cases of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Therapeutic Abortion (Cont'd.)

rape or incest. A blank Abortion Statement can be found in the Forms section of this manual.

Billing Notes for Abortions

When billing for any type of abortion, the principal procedure code must be the abortion. **Vaginal Delivery codes should not be used to report an abortion procedure.** The **only** exception to this rule is when the physician delivers the fetus, the gestation is questionable, and there is probability of survival. The medical record must contain documented evidence that the fetus was delivered by the physician.

1. Non-elective abortion procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code. Refer to Section 4 of this manual for non-elective abortion procedures.
2. For dates of service on or before **September 30, 2015**, ICD-9-CM diagnosis codes for elective therapeutic abortions are located on the SCDHHS website on the webpage.
3. For dates of services on or after **October 1, 2015, e**lective therapeutic abortions must ONLY be billed with ICD-10-CM diagnosis O04 range and Z33.2.

   Refer to Section 4 of this manual for elective therapeutic abortion procedure codes.
4. Legible medical records should be included with all abortions and should include admission history and physical, discharge summary, pathology report, operative report, physician progress notes, etc.
5. For dates of service on or before **September 30, 2015**, ICD-9-CM diagnosis codes that do not require documentation are located on the SCDHHS website on the webpage.

   For dates of service on or after **October 1, 2015**, the following ICD-10-CM diagnosis codes that do not require documentation:

ICD-10 CODE	DESCRIPTION
O01.0	CLASSICAL HYDATIDIFORM MOLE
O01.1	INCOMPLETE AND PARTIAL HYDATIDIFORM MOLE

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

ICD-10 CODE	DESCRIPTION
O01.9	HYDATIDIFORM MOLE, UNSPECIFIED
O02.81	INAPPROPRIATE CHANGE IN QUANTITATIVE HUMAN CHORIONIC GONADOTROPIN (HCG) IN EARLY PREGNANCY
O02.0	BLIGHTED OVUM AND NONHYDATIDIFORM MOLE
O02.89	OTHER ABNORMAL PRODUCTS OF CONCEPTION
O02.9	ABNORMAL PRODUCT OF CONCEPTION, UNSPECIFIED
O02.1	MISSED ABORTION
O36.4XX0	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSPECIFIED
O36.4XX1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1
O36.4XX2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2
O36.4XX3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3
O36.4XX4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4
O36.4XX5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5
O36.4XX9	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS
O42.00	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED WEEKS OF GESTATION
O42.019	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED TRIMESTER
O42.90	PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED WEEKS OF GESTATION
O42.919	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED TRIMESTER
O42.011	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, FIRST TRIMESTER
O42.012	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, SECOND TRIMESTER
O42.013	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, THIRD TRIMESTER
O42.02	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE
O42.911	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, FIRST TRIMESTER
O42.912	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, SECOND TRIMESTER
O42.913	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, THIRD TRIMESTER
O42.92	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

ICD-10 CODE	DESCRIPTION
O42.10	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED WEEKS OF GESTATION
O42.111	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, FIRST TRIMESTER
O42.112	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, SECOND TRIMESTER
O42.113	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, THIRD TRIMESTER
O42.119	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED TRIMESTER
O42.12	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE

Questions or difficulty with the processing of claims for abortion services should be directed to the PSC at 1-888-289-0709 or you may submit an online inquiry at http://www.scdhhs.gov/contact-us.

Back/Spinal Surgery and Other Back Procedures

Back/spinal surgery and other back procedures require prior authorization. The QIO, KEPRO, is responsible for reviewing and approving prior authorization requests using InterQual criteria.

Reduction Mammaplasty

Reduction mammaplasty for large, pendulous breasts on a female may be considered medically necessary and not a cosmetic procedure when InterQual screening criteria is met. Prior authorization is required for all ages.

Adolescent Female Reduction Mammaplasty

Surgery should be delayed when possible to allow the ultimate contour and shape of the breast to develop and avoid the possible complications of deformity from scar tissue and continued growth developing after surgery.

Repeat Female Reduction Mammaplasty

Repeat Female Reduction Mammaplasty may be considered when supporting documentation meets InterQual screening criteria.

Reconstructive Breast Surgery

Reimbursement is allowed for reconstructive breast surgery following a mastectomy when performed for the removal of cancer or for prompt repair of accidental injury. Reimbursement is also allowed for the reconstruction of both breasts following a bilateral mastectomy when

Reconstructive Breast Surgery (Cont'd.)

medical evidence supports the removal of both breasts because of the high incidence for the development of cancer in the unaffected breast**.**

Prior authorization must be obtained. The QIO, KEPRO, is responsible for prior authorization requests. InterQual screening criteria applies.

Breast reconstruction done for cosmetic reasons is non-covered. Augmentation is non-covered under all circumstances. Payment is made for special bras through the Durable Medical Equipment program for women who have undergone any type of mastectomy.

For a list of codes requiring PA, see "Procedure Codes Requiring Prior Authorization" in Section 4.

Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary. Prior authorization must be obtained by the attending physician. The South Carolina Medicaid Program Request for Prior Approval form and all necessary documentation should be submitted to the QIO, KEPRO. InterQual screening criteria applies.

Adolescent Male Gynecomastia

Surgery should be delayed when possible to allow the enlargement of the adolescent male mammary glands to regress.

Repeat Male Gynecomastia

Repeat Male Gynecomastia may be considered when supporting documentation meets InterQual screening criteria.

Obesity

Obesity itself cannot be considered an illness. The most common cause is caloric intake that is persistently higher than caloric output. Reimbursement may not be made for treatment of obesity alone since this treatment cannot be considered reasonable and necessary for the diagnosis or treatment of an illness or injury. However, although obesity is not in itself an illness, it may be caused by illnesses such as hypothyroidism, Cushing's disease, and hypothalamic lesions. In addition, obesity can aggravate many cardiac and respiratory diseases as well as diabetes and hypertension. Therefore, services related to the treatment of obesity could be covered services when such services are an integral and necessary part of a course of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Obesity (Cont'd.)

treatment for one of these illnesses. The following services are not covered by Medicaid:

- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon for treatment of obesity

Bariatric Surgery

Bariatric surgery is a covered service for members who meet InterQual guidelines for medical necessity.

Prior authorization for bariatric surgery procedures is required from the QIO, KEPRO. InterQual screening criteria applies.

Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The Panniculectomy procedure includes a Lipectomy. An Abdominoplasty is the excision of excessive skin and subcutaneous tissue. The Abdominoplasty is considered an add-on procedure to the Panniculectomy and also includes a Lipectomy.

The following conditions must be met for coverage by Medicaid:

- It is medically necessary for the individual to have such surgery.
- The surgery is performed to **correct** an illness that was caused by the pannus or aggravated by the pannus.

Prior authorization is required and requests may be submitted to the QIO, KEPRO. InterQual screening criteria applies.

Positron Emission Tomography (PET) Scans

SCDHHS will reimburse for certain Positron Emission Tomography (PET) scans. PET scan reimbursement is limited to two per twelve (12) months. PET scans will be covered only for the staging and restaging of cancer malignances. They should not be utilized for screening purposes. The use of PET scans to monitor tumor response during a planned course of therapy is not covered.

Restaging only occurs after a course of treatment is completed. The clinical applications for coverage include services relating to Brain Cancer, Breast Cancer, Colorectal Cancer, Esophageal Cancer, Head and Neck

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Positron Emission Tomography (PET) Scans (Cont'd.)

Cancers, Lung Cancer, Lymphoma, Melanoma, Refractory Seizures, Solitary Pulmonary Nodule, and Thyroid Cancer.

PET scans will be subject to retrospective review to include paid inpatient/outpatient hospital claims and physician claims. Documentation must be maintained in the beneficiary's medical records to support the medical necessity of the procedure.

Dental Services

Adults

Beneficiaries over the age of 21 may be eligible for dental services only if the services are delivered in preparation for or during the course of treatment for one or more of the following conditions:

- Organ transplants
- Chemotherapy for cancer treatments
- Radiation of the head and/or neck for cancer treatments
- Total joint replacement
- Heart valve replacement
- Treatment of trauma related injuries administered in a hospital or outpatient facility

Children Under Age 21

Comprehensive dental services for beneficiaries under age 21 are covered services. Emergency and non-emergency dental services may be provided in the hospital setting for patients who are physically or mentally handicapped, patients needing health maintenance supervision, or patients who for other reasons or conditions are unable to be treated in an office setting. In these cases, medical documentation may be required to establish medical necessity.

For further information regarding dental services, please contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

End Stage Renal Disease (ESRD) and Dialysis

The following guidelines define policy and procedures as they relate to patient services and providers involved in end stage renal disease treatments.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicare/Medicaid (Dually Eligible)

Medicare is the primary sponsor for ESRD services. Medicaid reimburses as **primary** sponsor for the initial 90-day waiting period required for Medicare coverage. If Medicare coverage is denied after the 90-day waiting period, notify PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Medicaid will not reimburse for ESRD services after the initial 90-day waiting period when a Medicare determination is still pending. Medicaid will not reimburse as primary sponsor for any Medicare-covered services until a denial of eligibility from the Social Security Administration is received. The 90-day waiting period is not required by Medicare for individuals who are candidates for a renal transplant or for those on home dialysis.

Claims submitted to Medicaid prior to the patient being enrolled with Medicaid as an ESRD patient will reject. All ESRD Enrollment Medicaid Recipient forms must be submitted to:

SCDHHS
Division of Hospital Services
Attn: ESRD Representative
Post Office Box 8206
Columbia, SC 29202-8206

Inpatient Dialysis

When an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. Medicaid sponsors all medically necessary services related to renal disease care according to the above guidelines regardless of the reason for admission.

Outpatient Dialysis

Medicaid will sponsor outpatient services related to end stage renal disease treatment under the guidelines outlined above provided the patient is enrolled with Medicare and Medicaid as an ESRD patient **and** the hospital is certified as a hospital-based ESRD facility. Hospitals presently certified are Palmetto Richland Memorial Hospital, St. Francis Community Hospital, the Medical University of South Carolina, Carolinas Hospital System, Hampton Regional Medical Center, Charlotte Memorial Hospital, and the Medical College of Georgia. The facility is

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Dialysis (Cont'd.)

responsible for ESRD enrollment of the patient with Medicare and Medicaid. See the ESRD Enrollment Medicaid Recipient, DHHS Form 218, in the Forms section of this manual. The initial outpatient claim must indicate the date of the first dialysis treatment and certify that a Medicare application has been submitted.

Home Dialysis

Medicare is the primary sponsor for patients receiving home dialysis services and Medicaid, if available, is the secondary sponsor. The Social Security Administration does not require a 90-day delay for home services and Medicare will reimburse from the initial course of treatment.

Should Medicare deny coverage for a patient entered on a program of home dialysis, Medicaid will sponsor treatment only if the hospital is certified for such procedures. Note that being certified for maintenance dialysis does not automatically certify the facility for home dialysis.

The hospital-based facility is responsible for the procurement, delivery, and maintenance of the equipment and supplies. The reimbursement rate includes all medically necessary services for home dialysis. Additional charges for home supplies or equipment are non-covered and claims indicating such will be denied.

Kidney Transplants

Prior approval is **not** required for kidney transplants. Please refer to "Organ Transplants" in this section for additional information.

Hyperbaric Oxygen Therapy

Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Reimbursement for HBO therapy is limited to that which is administered in a chamber (including the one-man unit) for the following conditions only:

- Acute carbon monoxide intoxication
- Decompression illness
- Gas embolism
- Gas gangrene

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Conditions (Cont'd.)

- Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened.
- Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment, when loss of function, limb, or life is threatened.
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management
- Osteoradionecrosis as an adjunct to conventional treatment
- Cyanide poisoning
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
- Soft tissue radionecrosis as an adjunct to conventional treatment

Pain Management Services

The complaint of pain remains the single greatest reason for seeking medical attention. It is of the utmost importance that any medical provider seeks the source of the pain as well as work to relieve and resolve the pain. Patient history must be reviewed to ensure all areas of treatment have been explored. The primary objectives of pain management must be to:

- Eliminate the use of optional health care services for primary pain complaints
- Increase physical activities and return the patient to productive activity
- Increase the patient's ability to manage pain and related problems
- Reduce the use and misuse of medication
- Decrease the intensity of subjective or illusory pain

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

External Infusion Pumps

The condition of external infusion pumps is covered for the following conditions:

- Opioid drugs for intractable cancer pain
- Treatment for acute iron poisoning or iron overload
- Chemotherapy for liver cancer
- Treatment for thromboembolic disease and/or pulmonary embolism

Other uses of the external infusion pump may be reimbursable if the provider can document the medical necessity and appropriateness of this type of therapy and pump for the individual patient. Prior approval must be requested in writing for a condition other than those listed above.

Non-Covered External Infusion Pumps

External infusion pumps are non-covered for insulin in the treatment of diabetes mellitus.

Spinal Cord Neurostimulators

The implantation of spinal cord neurostimulators will be covered for the treatment of severe and chronic pain. InterQual screening criteria applies.

The implantation of the neurostimulator may be performed on an inpatient or outpatient basis according to medical necessity.

Implantable Infusion Pumps

The use of implantable infusion pumps is covered for the following conditions:

1. Chemotherapy for Liver Cancer — The implantable pump is covered for the treatment of liver cancer in patients in whom the metastases are limited to the liver, and where either of the following applies:
   a) The disease is unresectable.
   b) The patient refuses surgical excision of the tumor.
2. Anti-Spasmodic Drugs for Severe Spasticity — An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (*e.g.*, Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Implantable Infusion Pumps (Cont'd.)

following criteria:

a) As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control such as oral anti-spasmodic drugs, because either these methods fail to adequately control the spasticity or produce intolerable side effects.

b) Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

3. Treatment of Chronic Intractable Pain — An implantable pump is covered when used to administer opioid drugs (*e.g.*, morphine) intrathecally or epidurally for the treatment of severe or chronic intractable pain in patients who have a life expectancy of at least three months and who have proven unresponsive to less invasive medical therapy, as determined by the following criteria:

   a) Medical documentation must reflect the coordination and treatment of the cause of pain.

   b) The patient's history must indicate that he or she would not respond adequately to non-invasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated reaction to pain).

   c) A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief and an acceptable degree of side effects (including effects on the activities of daily living).

Determinations may be made on coverage of other uses for implantable infusion pumps if the provider can verify the following:

- The drug is reasonable and necessary for treatment of the individual patient.
- It is medically necessary that the drug be administered by an implantable infusion pump.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Implantable Infusion Pumps (Cont'd.)

- The FDA-approved labeling for the pump must specify that the drug being administered and the purpose for its administration is an indicated use for the pump.

Non-Reimbursable Services

There is no reimbursement to physicians or CRNAs for the setup or subsequent daily management of patient-controlled analgesia (PCA) pumps. Behavioral modification, physical therapy, psychiatric services, and related services are non-compensable as pain management or pain therapy services.

SPECIAL COVERAGE GROUPS

Family Planning Services

Family planning services are defined as those services that prevent or delay unwanted or unintended pregnancies. These services include pregnancy prevention services for males (vasectomies) or females of reproductive age (typically between the ages of 10-55 years).

Family planning services do not require a referral or prior authorization for beneficiaries in Medicaid's managed care programs. All services rendered to dually eligible, both Medicare and Medicaid, patients should be filed to Medicare first. Some family planning services which are non-covered by Medicare are reimbursed by Medicaid.

For billing procedures, contact the PSC at 1-888-289-0709, submit an online inquiry, http://www.scdhhs.gov/contact-us, or refer to the Physicians Services Provider Manual at http://www.scdhhs.gov/contact-us.

Covered Services

Family planning services may be prescribed and rendered by physicians, hospitals, clinics, pharmacies, or other Medicaid providers recognized by state and federal laws and enrolled as Medicaid providers. They include family planning examinations, counseling services related to pregnancy prevention, contraceptives, family planning related laboratory services, etc., and sterilizations (including vasectomies) with a completed sterilization consent form (located in the Forms section of this manual). All family planning services must be billed using the appropriate CPT or HCPCS code with the FP modifier (service provided as part of family planning program)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services (Cont'd.)

and/or appropriate family planning diagnosis code. Hospital claims for family planning services are not required to report the FP modifier.

Non-Covered Services

Services required to manage or treat medical conditions and/or diseases, whether or not such procedures are also related to preventing or delaying pregnancy, are not eligible as family planning. Services to address side effects or complications associated with various family planning methods requiring medical interventions other than changing the birth control method (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) should not be billed using the FP modifier (service provided as part of family planning program) and/or family planning diagnosis code.

The following are also not considered family planning services:

- For dates of service on or before **September 30, 2015**, **r**outine gynecological exams (diagnosis code V72.3) in which contraceptive management is not provided

  For dates of service on or after **October 1, 2015**, routine gynecological exams (diagnosis codes Z01.411, Z01.419, and Z01.42) in which contraceptive management is not provided
- Services normally rendered for pregnancy prevention that are rendered for other medical purposes (*e.g.*, administering Depo-Provera for endometriosis)

Many procedures that are performed for "medical" reasons also have family planning implications. When services other than family planning are provided during a family planning visit, these services must be **billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable**. Some examples of these include:

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when a beneficiary enters the hospital for sterilization purposes, but then opts out of the procedure

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services (Cont'd.)

- Removal of an IUD due to a uterine or pelvic infection
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Diagnostic or screening mammograms
- Medical complications requiring treatment (for example, perforated bowel or bladder tear) caused by, or following, a family planning procedure
- Any procedure or service provided to a woman who is known to be pregnant
- Removal of contraceptive implants due to medical complications
- Services to a woman who has been previously sterilized

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Family Planning Services

Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage in order to be eligible. Family Planning provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventative health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a **limited set of services**. Services provided to men and women enrolled in Family Planning that are not specifically outlined below are the sole responsibility of the beneficiary.

Examinations, Visits, Biennial Physical Examinations, Family Planning Counseling, and screenings are not covered in the ASC, ESRD, and Infusion Center Clinic Settings.

Long Acting Reversible Contraceptives (LARCs)

Any LARC billed to SCDHHS by a pharmacy will be shipped directly to the provider's office for insertion. Providers should take extra care to ensure that they bill Medicaid only for reimbursement of the insertion of the device, and not the device itself, when it is obtained and billed through the pharmacy benefit.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Long Acting Reversible Contraceptives (LARCs) (Cont'd.)

Providers ordering LARCs through the pharmacy benefit must order them through the following specialty pharmacies:

• Paragard®	Direct	877-727-2427
• Mirena®/Skyla®	CVS	803-551-1030
• Implanon®/ Nexaplanon®	CVS	800-571-2767

The option for providers to purchase these devices directly and bill them via the traditional buy and bill mechanism will continue. All Family Planning Services should be billed using the appropriate CPT or HCPCS code with an FP modifier (service provided as part of family planning program)and/or appropriate diagnosis code.

Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Covered LARCs:

Kyleena®	J7296
Liletta®	J7297
Mirena®	J7298
ParaGuard®	J7300
Skyla®	J7301
Implanon®	J7307

Sterilization

For all elective sterilizations, SCDHHS requires the provider and beneficiary to complete a Consent for Sterilization Form located in the Forms section of this manual. The Consent for Sterilization Form (DHHS Form 687) has been designed to meet all federal requirements associated with elective sterilizations. The physician should submit a properly completed consent form with his

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization (Cont'd.)

or her claim so that all providers including Clinics and Hospitals may also be reimbursed.

Definitions as described in the Code of Federal Regulation

Sterilization – Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Institutionalized Individual – An individual who is:

- Involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness or
- Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness

Mentally Incompetent Individual – Means an individual who has been declared mentally incompetent by a federal, state, or local court. All sections of the Consent for Sterilization Form must be completed when submitted with the claim for payment. Each sterilization claim and consent form is reviewed for compliance with federal regulations.

Requirements

In order for Medicaid to reimburse for an elective sterilization the following requirements must be met:

- The Consent for Sterilization Form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be 21 years old at the time the consent form is signed.
- The beneficiary cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the beneficiary's choice may be present during the consent interview.) The family planning counseling

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Requirements (Cont'd.)

or family planning education/instruction procedure code may be billed when this service is rendered and documented.

- A copy of the consent form must be given to the beneficiary after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must pass between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (*e.g.,* day one begins the day after the signature). No one can sign the form for the individual.

Exceptions to the 30 day waiting period are:

- Premature Delivery – The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a Cesarean section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- Emergency Abdominal Surgery – The emergency does not include the operation to sterilize the beneficiary. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30 day waiting period. Informed consent may not be obtained while the beneficiary to be sterilized is:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol, controlled substances, or other substances which may affect the beneficiary's judgment.

Consent for Sterilization Form

If the consent form was correctly completed and meets all federal regulations, then the claim will be approved for payment. If the consent form does not meet the federal regulations, the claim will reject and a letter sent to the physician explaining the rejection.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

If the consent form is not submitted attached to the claim, the claim will be rejected and a new claim will need to be filed complete with the Consent for Sterilization Form attached.

Listed below are explanations of each field that must be completed on the consent form and whether it is a correctable error.

Consent to Sterilization

Name of the physician or group scheduled to do the sterilization procedure. (If the physician or group is unknown, put the phrase "OB on Call"): Correctable Error.

- Name of the sterilization procedure (*e.g.*, bilateral tubal ligation): Correctable Error.
- Birth date of the beneficiary (The beneficiary must be 21 years old when he or she gives consent by signing the consent form 30 days prior to the procedure being performed.): Correctable Error.
- Beneficiary's name (Name must match name on CMS-1500 form.): Correctable Error.
- Name of the physician or group scheduled to perform the sterilization or the phrase "OB on call;" Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Beneficiary's signature. (If the beneficiary signs with an "X," an explanation must accompany the consent form.): Non-correctable error.
- Date of Signature: Non-correctable error without detailed medical record documentation.
- Beneficiary's Medicaid ID number (10 digits): Correctable Error.

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language (*e.g.*, Spanish, French, etc.), the interpreter must complete this section. If an interpreter was not necessary, put "N/A" in these fields: Correctable Error.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

Statement of Person Obtaining Consent

- Beneficiary's name: Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Signature and date of the person who counseled the beneficiary on the sterilization procedure: This date must be the same date of the beneficiary's signature date.
- Signature is not a correctable error.
- Date is not a correctable error without detailed medical record documentation.
- If the beneficiary signs with an "X," an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

Physicians Statement

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure (This date must match the date of service that you are billing for on the CMS-1500.): Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Estimated Date of Confinement (EDC) is required if sterilization is performed within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours are required to pass before the sterilization procedure may be done: Correctable Error.
- An explanation must be attached if emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours are required to pass before the sterilization, and the sterilization procedure may not be the reason for the emergency surgery.
- Physician signature and date: a physician's stamp is acceptable.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Consent for Sterilization Form (Cont'd.)

The rendering or attending physician must sign the consent form and bill for the service. The Consent Form must be dated on the same date as the sterilization or after. The date is **not a correctable error** if the date is prior to the sterilization without detailed medical record documentation. In the license number field, put the rendering physician's Medicaid legacy Provider ID or NPI number. Either the group or individual Medicaid legacy Provider ID or NPI is acceptable.

Billing Notes for Sterilization and Other Related Procedures

Under the following circumstances, bill the corresponding sterilization procedure codes:

Essure Sterilization Procedure

Effective with dates of service prior to May 31, 2010, SCDHHS will reimburse for the Essure Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from performing a safe and effective laparoscopic tubal ligation. Reimbursement will be provided for any of the following criteria:

- Morbid Obesity (BMI of 35 or greater)
- Abdominal mesh that mechanically interferers with the laparoscopic tubal ligation
- Permanent colostomy
- Multiple abdominal/pelvic surgeries with documented severe adhesions
- Artificial heart valve requiring continuous anticoagulation
- Any severe medical problems that would contraindicate laparoscopy because of anesthesia considerations. (This must be attested in the request for prior approval that general anesthesia would pose a substantial threat to beneficiaries life.)

Effective with dates of service on or after June 1, 2010, SCDHHS removed the prior authorization and criteria requirements for the Essure sterilization procedure. The procedure will be covered when performed in an inpatient or outpatient hospital setting or in a physician's office. SCDHHS will reimburse for the implantable device by utilizing the Healthcare Common Procedure Coding

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes for Sterilization and Other Related Procedures (Cont'd.)

System (HCPCS) code A4264 with the FP modifier (service provided as part of family planning program) appended, and the professional service will be reimbursed utilizing the CPT code 58565 must also, have the FP modifier appended. Procedure code 58340 (hysterosalpingogram) and 74740 (radiological supervision and interpretation) should be billed as follow-up procedures 90 days after the sterilization. A Consent for Sterilization Form must be completed and submitted with the claim. Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a Consent for Sterilization Form.

Sterilization Codes and Services:

- **58605 –** Tubal ligation following a vaginal delivery by a method except laparoscope
- **58611** – Tubal ligation following C-section or other intra-abdominal (tubal ligation as the minor procedure) surgery
- **58600** – Ligation, transection of fallopian tubes; abdominal or vaginal approach
- **58615** – Occlusion of fallopian tubes by device
- **58670** – Laparoscopic sterilization by fulguration or cauterization
- **58671** – Laparoscopic sterilization by occlusion by device
- **55250** – Vasectomy

Use of procedure codes 55250, 58600, 58605, 58611, 58615, 58670, and 58671 should always be billed hardcopy with a copy of the Consent for Sterilization form attached.

Non-Covered Services

Services beyond those outlined in this section that are required to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to family planning, are not covered under the Family Planning Program. Services to address side effects or complications (*e.g.,* blood clots, strokes, abnormal Pap smears, etc.) associated with various family planning methods requiring medical interventions (*e.g.,* blood clots, strokes, abnormal Pap smears, etc.) other than changing the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services (Cont'd.)

birth control method should not be billed using an FP modifier (service provided as part of family planning program) or Family Planning diagnosis code. When services other than Family Planning are provided during a family planning visit, these services must be billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable. Examples of these services include:

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when a beneficiary enters an outpatient hospital/facility for sterilization purposes, but then opts out of the procedure
- Inpatient hospital services
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Treatment of medical complications (for example, perforated bowel or bladder tear) caused by, or following a Family Planning procedure
- Any procedure or service provided to a woman who is known to be pregnant

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Hospice

Hospice services provide palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals. In addition to meeting the patient's medical needs, hospice care addresses the physical and psychosocial needs of the patient's family and caregiver.

Hospice services are available to Medicaid beneficiaries who choose to elect the benefit and who have been certified to be terminally ill with a life expectancy of six months or less by their attending physician and the medical director of hospice.

Hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. The services below are covered hospice services:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has at least a bachelor's degree and is working under the direction of a physician
- Physicians' services provided by the hospice medical director or physician member of the interdisciplinary group
- Short-term inpatient care provided in either a participating hospice inpatient unit or a participating hospital or nursing home that additionally meets the special hospice standards regarding staffing and patient care
- Medical appliances and supplies, including drugs and biologicals. Only those supplies used for the relief of pain and symptom control related to the terminal illness are covered.
- Home health aide services and homemaker services
- Physical therapy, occupational therapy, and speech language pathology services
- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home

A beneficiary who elects the hospice benefit must waive all rights to other Medicaid benefits for services related to treatment of the terminal condition for the duration of the election of hospice care. Specific services that must be waived include:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice)
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for services:
    - Provided (either directly or under arrangement) by the designated hospice

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

- Provided by another hospice under arrangements made by the designated hospice
- Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for the services

Services Not Related to the Terminal Illness

Services provided by hospitals for care not related to the terminal illness must be pre-approved by the hospice provider. The hospital will contact the hospice provider for confirmation that the service does not relate to the terminal illness and a prior authorization number to be included on that provider's claim form. The hospice prior authorization number on the claim certifies that the services provided are not related to the terminal illness or are not included in the hospice plan of care. If the authorization number is not included on the claim form it will be rejected and returned to the provider. Services that require prior authorization are:

- Hospital
- Emergency Room
- Pharmacy
- Mental Health
- Drug, Alcohol, and Substance Abuse Services
- Audiology
- Psychologist Services
- Speech Therapy
- Occupational Therapy
- Ambulatory Surgery Clinics
- Medical Rehabilitation Services
- School-Based Services
- Physical Therapy
- Private Duty Nursing
- Podiatry
- Health Clinics
- County Health Departments

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Services Not Related to the Terminal Illness (Cont'd.)

- Home Health
- Home- and Community-Based Services
- Durable Medical Equipment

The authorization number should be entered in field 63 of the UB-04. Claims submitted by these service providers without the required hospice authorization will reject. If billing issues cannot be resolved with the hospice, contact PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for assistance.

Qualified Medicare Beneficiary (QMB)

Medicaid beneficiaries who are also Qualified Medicare Beneficiaries (QMBs) are eligible for payment of the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries.

Please refer to the Medicaid Web-Based Claims Submission Tool, in Section 1, for instructions on how to access beneficiary information, including QMB status.

MEDICAID MANAGED CARE

Medical Homes Network – Medically Complex Children's Waiver

MCCW Emergency Services

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient services does require authorization. The hospital should contact the PCP for authorization within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Managed Care Organizations (MCOs)

MCO Emergency Room Services

The MCO must make provisions for, and advise all Medicaid MCO program members of the provisions governing, in- and out-of-service area use of emergency visits. The MCO is responsible for payment to providers and for determining whether or not an emergency exists for Medicaid MCO program members. The MCO must make prompt payment for covered emergency services that are furnished by providers that have no contractual arrangements with the MCO to provide such services.

For additional information on the MCO program, please call the Bureau of Managed Care at (803) 898-4614.

MCO Program Billing Notes

1. In order to avoid risk of non-payment for services, all hospital providers should check the beneficiary's eligibility to see if the beneficiary is enrolled in a Medicaid MCO. Services rendered to a beneficiary who is enrolled in a Medicaid MCO require the rendering provider to follow the prior approval and/or coordination of care as directed by the Medicaid MCO.
2. Hospital providers should file claims for Medicaid MCO program members to the MCO. Claims should be filed in accordance with the Medicaid MCO's claim filing procedures. Claims submitted to SCDHHS for MCO program members will be rejected if services are within the MCO's scope of service.
3. A beneficiary's program status on date of admission to the hospital will determine which program requirements the hospital will follow.
4. When reporting inpatient and outpatient data to the Office of Research and Statistics (ORS) for Medicaid MCO program members, the payer carrier code (item 50A-C) should list the carrier code assigned to the MCO.

SECTION 3

BILLING PROCEDURES

TABLE OF CONTENTS

SECTION 3

BILLING PROCEDURES

TABLE OF CONTENTS

SECTION 3

BILLING PROCEDURES

TABLE OF CONTENTS

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

SOUTH CAROLINA MEDICAID BILLING PROCEDURES

Policies and procedures written in this section apply to all providers under the Hospital Services program who file claims with South Carolina Medicaid. The South Carolina Department of Health and Human Services (SCDHHS) wants to make billing as simple for providers as possible. This section contains "how-to" information on billing procedures such as how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments, refunds, and appeals. This section will assist you with these and other issues involving claims processing and payments, but may not answer all of your questions. You should direct any questions not addressed in this section to the SCDHHS Provider Service Center (PSC) or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Some of the policies and procedures written in this section are implemented in order to be in compliance with federal regulations. This is necessary to maintain federal financing for South Carolina's Medically Indigent Programs and Services.

TIME LIMIT FOR FILING CLAIMS

SC Medicaid policy requires that only "clean" claims received and entered into the claims processing system within one year from the date of service or date of discharge for inpatient claims will be considered for payment. A "clean" claim is error free and can be processed without obtaining additional information from the provider or from another third party. Claims with an edit code of 509 or 510 on remittances, or CARC 29 on an electronic Remittance Advice, have not met these criteria. It is the provider's responsibility to follow up on claims in a timely manner to ensure that all claims are filed and corrected within Medicaid policy limits.

USUAL AND CUSTOMARY RATES

Providers are required to bill their usual and customary rate when filing Medicaid claims. Charges to Medicaid cannot exceed charges to private patients, whether they are self-pay or covered by another carrier. Billing of covered procedures prior to the date of service is prohibited.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Claims for Medicare Coinsurance and Deductible

All claims not paid in full by Medicare must be filed directly to Medicaid as claims no longer cross over for automatic payment review.

Claims for payment of Medicare coinsurance and deductible amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or six months following the date of Medicare payment, whichever is later.

Retroactive Eligibility

Claims involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system **AND**
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

Claims involving retroactive eligibility that are received more than three years from the date of service will be rejected with edit code 533 (date of service more than three years old) and CARC 29 (the time limit for filing has expired).

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

BENEFICIARY COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of Medicaid by imposing copayments upon them. A copayment is the amount of money the beneficiary is expected to pay to the provider at the time services are received.

SC Medicaid has required a copayment from beneficiaries toward the cost of their care since March 2004. Medicaid beneficiaries may not be denied service if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

As of July 2011, SCDHHS revised the beneficiary copayment amounts for Medicaid Services. Please refer to Appendix 3 of this manual for the Copayment Schedule. Also, pursuant to this change, persons ages 19 and older who are enrolled in a waiver program through Community Long Term Care or the SC Department of Disabilities and Special Needs must make a copayment for their State Plan services according to established policy. Members of MCOs should contact their individual plan for information about copayments applicable in their plan.

Copayment Exclusions

Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF/IID, members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following services are not subject to a copayment:** Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services**.**

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Claim Filing Information

The collection of copayment should not be entered in the Rsvd for NUCC use, field 30, on the CMS-1500 claim form; this would result in an additional reduction in payment.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

HOSPITAL CLAIMS SUBMISSION

Medicaid claims must be filed on the UB-04 claim form. Alternative forms are not acceptable. Those using computer-generated forms are not exempt from Medicaid claims filing requirements. Your proposed format should be reviewed by the SCDHHS data processing personnel before it is finalized to ensure that it can be processed.

Those who intend to utilize an automated billing system should contact the Electronic Media Claims (EMC) representative in the Bureau of Information Systems (BIS) at (803) 898-2988 to ensure compatibility of data transmission.

Hard Copy Claims

A hard copy claim must be sent to the appropriate post office box number. **Unless requested, claims should not be sent to the SCDHHS program representative's address.** Claims sent to an incorrect address will delay processing time.

Mailing Addresses

Claims for hospital medical charges are filed on the UB-04 claim form, following all program policies and billing instructions. Claims should be completed and sent to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

Claims for hospital-based physician services should be filed on the CMS-1500 (Centers for Medicare and Medicaid Services) Claim Form. Claims should be completed and sent to:

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Mailing Addresses (Cont'd.)

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

Claims recorded on magnetic tapes or ASCII diskettes should be sent to:

Medicaid Claims Control System (MCCS)
Post Office Box 2765
Columbia, SC 29202-2765

Claims may be submitted through a business agent provided the requirements in 42 CFR 447.10(f) are met.

Electronic Claims Submission

SCDHHS encourages electronic claims submission. For all electronic transactions, refer to the Implementation Guide and Companion Guide at http://www.scdhhs.gov/ for additional information. For assistance with Web Tool billing, contact the Medicaid EDI Support Center at 1-888-289-0709.

Trading Partner Agreement

All Medicaid providers submitting claims electronically for claims processing will be required to sign a Trading Partner Agreement (TPA). The TPA outlines basic requirements for receiving and sending electronic transactions with SCDHHS. For specific instructions or to obtain a TPA, visit: http://www1.scdhhs.gov/hipaa/Trading%20Partner%20Enrollment.asp or contact the EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709.

Providers should return the completed and signed SC Medicaid TPA Enrollment Form by mail or fax to:

SC Medicaid TPA
Post Office Box 17
Columbia, SC 29202
Fax: (803) 870-9021

If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file.

Note: SCDHHS distributes remittance advices electronically through the Web Tool. **All providers must complete a TPA in order to receive these transactions electronically.** Providers that currently use the Web Tool do not need to complete another TPA. Providers who have

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Trading Partner Agreement (Cont'd.)

previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by contacting the EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709.

Source documents for electronic claims must be retained by the provider for 72 months following payment.

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the SC Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC Medicaid. Please visit the SC Medicaid Companion Guides webpage at http://www.scdhhs.gov/resource/sc-medicaid-companion-guides to download the Companion Guides. Information regarding placement of NPIs, taxonomy codes, and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

- 837P Professional Health Care Claim
- 837I Institutional Health Care Claim
- 835 Claim Payment/Advice
- 276/277 Claim Status Inquiry/Response
- 270/271 Eligibility Verification Request/Response
- 278 Prior Authorization

Transmission Methods

An Electronic Data Interchange (EDI) transaction is the movement of data between two entities. EDI software enables providers to submit claims directly to SC Medicaid.

The following options may be used to submit claims electronically:

Tapes, Diskettes, CDs, and Zip Files

A biller using this option records transactions on the specified media and mails them to:

SC Medicaid Claims Control System
Post Office Box 2765
Columbia, SC 29202-2765

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

File Transfer Protocol

A biller using this option exchanges electronic transactions with SC Medicaid over the Internet.

SC Medicaid Web-based Claims Submission Tool

The SC Medicaid Web-based Claims Submission Tool is a free, online Web-based application for submitting HIPAA-compliant professional claims, institutional claims, and associated adjustments to SC Medicaid. The Web Tool offers the following features:

- Providers can submit online CMS-1500 and UB claims and attach supporting documentation.
- The List feature allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes, etc.). During claims entry the user has the ability to select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.
- Providers can check claims status.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices.
- Providers can change their own passwords.

The minimum requirements necessary for using the Web Tool are:

- Signed SC Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 9.0, 10, 11); Firefox; Safari; or Google Chrome
- Internet Service Provider (ISP)
- Pentium series processor or better processor (recommended)
- Minimum of 1 gigabyte of memory
- Minimum of 20 gigabytes of hard drive storage

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

SC Medicaid Web-based Claims Submission Tool (Cont'd.)

Note: In order to access the Web Tool, all users must have individual login IDs and passwords.

Refunds

Refund checks must be accompanied by a completed Form for Medicaid Refunds (DHHS Form 205). SCDHHS must be able to identify the reason for the refund, the beneficiary's Medicaid number and name, the provider's Medicaid number, and the date of service to post the refund correctly. A copy of Form 205 can be found in the Forms section of this manual.

All refund checks should be made payable to SCDHHS and mailed to:

South Carolina Healthy Connections
Division of Finance
Post Office Box 8355
Columbia, SC 29202-8355

If a provider submits a refund to SCDHHS and subsequently discovers that it was the refund was made in error, SCDHHS must receive a credit adjustment request within 90 days of the refund.

Appeals

SCDHHS maintains procedures ensuring that all SC Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in SC Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

In accordance with SCDHHS regulations, a provider wishing to file an appeal **must** send a letter requesting a hearing along with a copy of the notice of adverse action or detail statement outlining the reason for the appeal request and any supporting documentation reflecting the denial in question. Letters requesting an appeal hearing **must** be sent to the following address:

SCDHHS
Division of Appeals and Fair Hearings
Post Office Box 8206
Columbia, SC 29202-8206

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Appeals (Cont'd.)

The request for an appeal hearing must be made within thirty days of the date of receipt of the notice of adverse action or thirty days from receipt of the remittance advice reflecting the denial, whichever is later. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

Billing and Collection Agencies

SCDHHS is subject to a number of federal restrictions concerning the entities to whom payments may be made and the entities to whom beneficiary information may be released.

Federal Medicaid regulations (42 CFR 447.10 (f)) allows Medicaid to make payment for services to a provider's "business agent," such as a billing service or an accounting firm, only if the agent's compensation meets all the following conditions:

- It is related to the cost of processing and billing.
- It is not related on a percentage or other basis to the amount that is billed or collected.
- It is not dependent upon the collection of the payment.

If the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, Medicaid is not allowed to make payment to that agent.

The Centers for Medicare and Medicaid Services (CMS) has instructed states that the requirement regarding release of beneficiary information should parallel the limitations on payment. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration.

However, if no payment could be made to the agent because the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent. The manner in which the agent is dealt with by the Medicaid program is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

CODING REQUIREMENTS

Procedural Coding

The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires use of the medical code set that is valid at the time that the service is provided.

SCDHHS has eliminated the 90-day grace period for billing discontinued ICD-CM *(International Classification of Diseases, Clinical Modification)* and PCS (Procedural Coding System) codes. This means that providers no longer have the time between October 1 and December 31 to eliminate billing of codes that are discontinued on October 1.

The American Medical Association revises the nomenclature within the HCPCS coding system periodically. When a HCPCS procedure code is deleted, Medicaid discontinues coverage of the deleted code. New codes are reviewed to determine if they will be covered. Until the results of the review are published, coverage of the new code is not guaranteed.

The 90-day grace period for billing discontinued HCPCS (*Health Care Common Procedure Coding System*) and CDT (*American Dental Association's Current Dental Terminology*) codes has been eliminated. This means that providers no longer have the time between January 1 and March 31 to eliminate billing codes that are discontinued on January 1.

HCPCS consist of two levels of codes:

1. Level I codes are copyrighted by the *American Medical Association's Current Procedural Terminology, Fourth Edition* (CPT-4).
2. Level II codes are five-position alphanumeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association).

Claims that are noncompliant will reject with an appropriate edit code.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Code Limitations

Certain procedures within ICD or HCPCS may not be covered or may require additional documentation to establish the medical necessity or meet federal guidelines. Examples are elective sterilizations and abortions.

Unlisted Services and Procedures

A service or procedure may require the use of an unlisted HCPCS code. When reporting such services, claims must be filed using the HCPCS code that most closely describes the service or procedure that was performed. When this is not applicable, an unlisted procedure code may be used and the support documentation should be attached to the claim for adequate reimbursement.

National Correct Coding Initiative (CCI)

In 1996, CMS implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The Department of Health and Human Services program utilizes Medicare guidelines. Therefore, the agency will use CCI edits to evaluate billing of HCPCS codes by Medicaid providers in post-payment review of providers' claims. For assistance in billing, providers may access the CCI edit information online at the CMS Web site, http://ww.cms.hhs.gov.

National Provider Identifier

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These "typical" providers must apply for an NPI and share it with SC Medicaid. to obtain an NPI and taxonomy code, please visit http://www1.scdhhs.gov/openpublic/serviceproviders/npi%info.asp for more information on the application process.

When submitting claims to SC Medicaid, typical providers must use the NPI of the ordering/referring provider and the NPI and taxonomy code for each rendering, pay-to, and billing provider.

Atypical providers (non-covered entities under HIPAA) identify themselves on claims submitted to SC Medicaid by using their six-character legacy Medicaid provider number.

Diagnostic Codes

SC Medicaid requires that claims be submitted using the current edition of the *International Classification of Diseases, Clinical Modification (ICD-CM)*. Only Volumes

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Diagnostic Codes (Cont'd.)

1 and 3 are necessary to determine diagnosis codes and ICD-PCS surgical procedure codes, respectively.

For dates of service on or before **September 1, 2015**, diagnosis codes must be full ICD-9-CM diagnosis and ICD-PCS codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM/ICD-PCS.

For dates of service on or after **October 1, 2015**, diagnosis codes must be full ICD-10-CM diagnosis and ICD-PCS codes Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM/ICD-PCS.

Present On Admission (POA) Indicator

Medicaid will edit inpatient claims for a Present On Admission (POA) indicator. This indicator will distinguish conditions and diagnoses that are present at the time of the admission from those manifesting during the hospital stay.

For hard copy claims, the POA indicator will be placed at the eighth position of the Principal diagnosis field, Form Locator 67 and for each of the Secondary diagnosis fields, Form Locators 67-A through Q.

For dates of service on or before **September 1, 2015**, electronic claims submissions 837I should follow the guidelines published in conjunction with the UB-04 Data Specifications Manual and the ICD-9-CM official guidelines for coding and reporting. The POA indicator should also be reported for External Cause (E-Codes). E-code categories for which the POA Indicator is not applicable are exempt from editing.

For dates of service on or after **October 1, 2015**, electronic claims submissions should follow the guidelines published in conjunction with the UB-04 Data Specifications Manual and the ICD-10-CM official guidelines for coding and reporting. The POA indicator should also be reported for external causes of morbidity. External causes of morbidity categories for which the POA Indicator is not applicable are exempt from editing.

National Drug Code (NDC) Billing Requirements for Outpatient Hospital Setting

To comply with Centers for Medicare and Medicaid Services requirements related to the Deficit Reduction Act (DRA) of 2005, Medicaid will require providers billing for physician-administered drug products in the outpatient hospital setting to report the National Drug Code (NDC)

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

National Drug Code (NDC) Billing Requirements for Outpatient Hospital Setting (Cont'd.)

when using a drug-related Healthcare Common Procedure Coding System (HCPCS) code or Current Procedural Terminology (CPT) code. This would include all claims submitted electronically (837I), via the Web Tool and paper claim submissions.

Providers have the option to enter supplemental information (*i.e.,* Unit of Measurement, Unit Quantity, etc.) with the NDC; however, Medicaid will only edit for the presence of a valid NDC.

The NDC number submitted to Medicaid must be the NDC number on the package from which the medication was administered. All providers must implement a process to record and maintain the NDC(s) of the actual drug(s) administered to the beneficiary, as well as the quantity of the drug(s) given.

PAYMENT FOR SERVICES

Medicaid payment is considered payment in full. Once Medicaid is billed for covered services, the beneficiary may not be billed. Payment of inpatient services is based on a prospective payment system. Rates are developed for each facility. Payment of outpatient services is based on a fee schedule, which can be found in Section 4 of this manual and on the SCDHHS Web site.

Same Day Admission and Discharge

Payment for same day admission and discharge is half the per diem rate for the Diagnosis Related Group (DRG). Payment for a one-day stay (discharged the day after admission) is the per diem rate for the average length of stay for the DRG. When a hospital admission is one day or less, providers have the option to bill either of the following:

- An inpatient admission with payment as above
- An outpatient claim with observation, if ordered by a physician and substantiated by medical records

Note: Normal delivery/newborns, false labor, and death are paid a full DRG regardless of the length of stay.

Discharge/ Readmission Within 24 Hours

Inpatient services with a discharge and re-admission within 24 hours, for the same or related diagnosis, will be paid as one admission. In some instances payment may be made for both admissions, provided documentation supports both admissions.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Discharge/ Readmission Within 24 Hours (Cont'd.)

Claims for re-admissions after discharge must be sent hard copy with documentation. The provider should send the admission history and physical and discharge summary for both admissions. The documentation will be reviewed and one of the following determinations made:

- To combine the claims and pay as one admission
- To pay each admission separately
- To combine the claims and pay as one admission with a cost outlier

Note: False labor with a subsequent delivery, a patient leaving against medical advice and then being re-admitted, and a patient who transfers from acute care to a psychiatric or rehabilitative unit will be paid as two separate admissions.

SCDHHS has implemented the use of Condition Code B4 for the purpose of reporting a patient that is readmitted to the same acute care hospital on the same day for symptoms unrelated to the prior admission. The presence of Condition Code B4 in fields 18-28 will reimburse two full DRG payments, one for each admission.

Transfers to a Psychiatric or Rehabilitation Unit Within the Same or Different General Acute Hospital

SCDHHS will reimburse two DRG payments when a patient is transferred to a psychiatric unit or a rehabilitation unit within the same or different acute care hospital. The South Carolina Medicaid State Plan limits coverage of inpatient hospital services to general acute care hospitals and to psychiatric hospitals for services to individuals under age 21. Inpatient rehabilitative services provided in a distinct medical rehabilitation facility or a separately licensed specialty hospital are reimbursed only when provided under the umbrella of a general acute care hospital. Thus, the cost for both facilities is reported to Medicare on one Cost Report.

The hospital or unit that transfers the patient should use Patient Status code 62 (Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part unit of a hospital) or Patient Status code 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) in field 17 on the claim form.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Transfers to a Psychiatric or Rehabilitation Unit Within the Same or Different General Acute Hospital (Cont'd.)

The hospital or unit receiving the patient should use Source of Admission code 4 (Transfer from a Hospital) in field 15 on the claim form.

Services Performed at Another Facility

Charges for tests or procedures performed at a hospital other than the admitting hospital are included in the admitting hospital's DRG. The admitting hospital is responsible for reimbursing the performing hospital for their services.

Modifiers on Outpatient Surgery Claims

Three modifiers will affect payment for outpatient surgery claims: modifiers 50, 73, and 74. The appropriate modifier would be shown in field 44 after the HCPCS surgical code.

- Modifier 50 – Bilateral Procedure must be billed according to national coding guidelines. HCPCS codes billed with a 50 modifier will reimburse providers 150% of the assigned reimbursement rate. For example, if the HCPCS surgical code with no modifier paid the rate of $350, then the HCPCS surgical code with the 50 modifier would pay 150% of the rate or $525.
- Modifier 73 – Discontinued outpatient procedure prior to anesthesia administration
- Modifier 74 – Discontinued outpatient procedure after anesthesia administration

If modifier 73 or 74 is billed with a HCPCS surgical procedure code, the claim will not be priced as surgery reimbursement unless other surgeries appear on the claim. If there are multiple surgeries on the claim, the system will search for any payable surgery and price accordingly. If there are no other surgeries, the claim will continue to process for any payable services and price, non-surgical visit (Reimbursement Type 5) or TTT/Treatment, Therapy, Testing (Reimbursement Type 4) accordingly.

Replacement Claims

Replacement claims, bill type 117, 137, and 147, can only be used to replace a paid claim. If you file a claim and later realize that you omitted critical information, wait until the claim is paid or receives a rejection... A

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Replacement Claims (Cont'd.)

replacement claim can be filed even if the changes do not result in a different reimbursement. Also, medical records are no longer required for replacement claims.

Note: Replacement claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the replacement claim must be submitted hard copy.

Time Limits

Replacement claims must be received and entered into the claims processing system within **one year** from the date of service for outpatient claims or **one year** from the date of discharge for inpatient claims to be considered for payment. Replacement claims should not be submitted if the date of service has exceeded the one-year timely filing limit. Providers filing a replacement claim after the one-year filing limit will have the original payment recouped and the replacement claim rejected with the timely filing 510 edit code.

- A replacement claim submitted either electronically or hard copy will generate a recoupment of the original claim in its entirety. The replacement claim is then processed as a new claim with a new claim control number (CCN).
- If the recoupment of the original claim and the replacement claim process in the same payment cycle, they will appear together on the remittance advice.
- If the recoupment and the replacement claim do not process in the same payment cycle, you will see the recoupment on the first remit and the credit on a subsequent remittance advice. The subsequent remittance advice will include a check date for the provider to reference the remit showing the void.

Billing Notes

Please use the following steps when sending a hard copy replacement claim:

1. In field 4, use bill type 117 for an inpatient claim. Use bill type 137 or 147 (depending on the bill type of the original claim) for an outpatient claim.
2. Always enter the claim control number (CCN) of the paid claim in field 64.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Void Claims

Void/Cancel claims, bill type 118, 138, 148, can only be used to void a paid claim. The beneficiary number and provider NPI number of the void claim must be identical to those on the paid claim. Always enter the CCN of the paid claim in field 64.

Note: Void/Cancel claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the void/cancel claim must be submitted hard copy.

EMTALA (Emergency Medical Treatment and Labor Act)

Revenue code 451 should be billed for emergency room screenings that meet the federal EMTALA guidelines. Claims submitted to South Carolina Medicaid with revenue code 451 must have valid diagnosis codes and will pay an all-inclusive rate. In order to receive the correct payment for services provided, revenue codes 450 (Emergency General) and 451 (EMTALA) must not be billed on the same claim form.

Administrative Days

Payment for administrative days will be made at a per diem rate that includes drugs and supplies. The per diem rate is recalculated each October. Please refer to "Administrative Days" in this section for further billing requirements.

Physician Services

Payment for physician and resident services are made separately. Refer to the Medicaid Physicians Services Manual for billing instructions.

Third-Party Liability

Payment for claims that show a third-party payer will automatically be reduced by the third-party payment. When a third-party payment is equal to or greater than the Medicaid payment, no payment will be due from Medicaid. Refer to the Third-Party Liability portion of this section for information on cost avoidance.

MEDICARE/MEDICAID DUAL ELIGIBILITY

Medicare has two parts. Part A (Hospital Insurance) pays the expenses of a patient in a hospital, skilled nursing facility, hospice care, or at home for services provided by a home health agency. Part B (Medical Insurance) helps pay for physician services, outpatient hospital services, inpatient ancillary charges when Part A benefits are exhausted or nonexistent, medical services and supplies, home health services, outpatient physical therapy, and other health care services.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

MEDICARE/MEDICAID DUAL ELIGIBILITY (CONT'D.)

Many beneficiaries covered by Medicare Part B are also eligible for Medicaid benefits. For these individuals Medicaid pays:

- Part B insurance premiums
- Certain other charges sponsored by Medicaid but not covered by Medicare

In addition to the Part B coverage furnished to these individuals, some clients may have Part A coverage either by having worked a sufficient number of quarters to be eligible to receive Part A coverage, or by purchasing Part A coverage. In certain cases, Part A premiums are paid by Medicaid. For dually eligible Part A beneficiaries, Medicaid pays the following:

- Part A deductible, including blood deductible and coinsurance, or the difference between the Medicaid-allowed amount minus the amount paid by Medicare, whichever is less

Medicaid does not pay coinsurance during lifetime reserve days or sponsor a continued stay once lifetime reserve days are exhausted. Medicaid will sponsor an inpatient stay after lifetime reserve days are exhausted if the beneficiary is discharged from the hospital and readmitted within the same Medicare benefit period. A chart located in Section 2 details the Medicare and Medicaid payment responsibilities during an inpatient stay.

The provider should ask to see a beneficiary's Medicare card to determine the extent of his or her Medicare coverage. Inpatient and outpatient services for persons who are certified dually eligible should be filed with the Medicare intermediary.

Medicaid is secondary when other health insurance becomes effective during an inpatient stay. This includes the dually eligible beneficiary regardless of the effective date of the Medicare coverage.

PAYMENT METHODOLOGY FOR MEDICARE CROSSOVER CLAIMS

Medicare Part A Billing

If a patient has both Medicare and Medicaid, the claim should be filed with Medicare first. Then, the claim must be submitted to Medicaid on a UB-04 claim form or filed

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Medicare Part A Billing (Cont'd.)

electronically. A Medicare EOMB is not required.

The following information must be on the claim submitted to Medicaid:

1. Field 50 must contain the three-digit Medicare carrier code of 618 or the three-digit Medicare Advantage Plan carrier code. If the carrier code does not appear in field 50, the claim will reject to the provider.
2. Field 54 must be the actual amount of Medicare payment. This field should contain 0.00 if there was no payment by Medicare, either because the service was denied or because the patient has not met his or her Medicare deductible. Fields 31-34 A-B should be coded with the occurrence code of 24 or 25 and the date of denial if there was no payment from Medicare, either because the service was denied or because the patient has not met his or her Medicare deductible.
3. If a patient has Medicare and Medicaid, field 60 must contain the Medicare number of the patient.
4. If the patient has other insurance in addition to Medicare, the other insurance should be coded with the appropriate carrier code, policy number, and payment in the remaining fields, 50, 54, and 60. All of these entries must be on the same A-C line. If there was no payment from the other insurance, even if Medicare paid an amount, fields 31-34, A-B should be coded with the occurrence code of 24 and the date of denial.
5. Hospital providers must enter the Medicare Deductible and Coinsurance amounts, indicated on the Medicare EOB, on the UB-04 claim form as follows:
   - Use value code 09 and amount to enter the Medicare Part A coinsurance amount charged in the year of admission.
   - Use value code 11 and the amount to enter the Medicare Part A coinsurance amount charged in the year of discharge when the inpatient bill spans two calendar years.
   - Use value code A1, B1, or C1 and the amount, as appropriate, to correspond to the location of the Medicare Part A payer code 618 or the Medicare Advantage Plan carrier code in form locator 50 to enter the Medicare deductible

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Medicare Part A Billing (Cont'd.)

amount to be paid on the claim.

- Use value codes A2, B2, and C2 and the amount to enter the Part B coinsurance amount.
- Use value code 38 Blood Deductible Pints (The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.) along with the number of pints of blood. The number of pints is multiplied by the Blood Deductible amount, not to exceed 3 units. Value code 06 (Medicare Part A Blood Deductible) with the total cash blood deductible amount can be shown in fields 39-41, A-D; but this amount will not be considered in the payment methodology for Medicare crossover claims.

SCDHHS will pay the Medicaid claim payment less the amount paid by Medicare or the coinsurance, deductible, and blood deductible amount, whichever is less. If the total payment by Medicare exceeds what Medicaid will allow for the service, there will be no payment to the provider and the claim will be assigned edit code 555. (The third-party payment entered on the claim is greater than payment due from Medicaid.)

Medicare Part B Only Billing

Submit claims to Medicaid for all inpatient charges on the UB-04 form or electronically.

1. Enter Payer Code 620 (Medicare Part B only) in field 50.
2. Enter the prior payment in field 54.
3. Enter the Medicare identification number in field 60. **All of these entries must be on the same A-C line.**

Medicaid will calculate a DRG payment for the claim, subtract the prior payment amount, and pay the difference. In many cases, the prior payment by Medicare will be greater than Medicaid's payment, and a 555 edit will be assigned.

Note: Medicare Part B only coverage can no longer be identified by the suffix on the Medicare number. The beneficiary's Medicare card must be checked to determine the level of coverage.

UB-04 claims for inpatient Part B charges must be filed within the one-year time limit.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

MEDICAID COPAYMENTS

Effective, July 2011, persons ages 19 and older who are enrolled in a Medical Homes Network or participate in waiver programs through Community Long Term Care or the SC Department of Disabilities and Special Needs must make a copayment for their State Plan services according to established policy.

South Carolina Medicaid has required a minimum financial contribution from beneficiaries for the cost of their care since March 2004. See the Schedule of copayments in Appendix 3 of this manual.

Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF/IID), members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following services are not subject to a copayment:** Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services**.**

- **Inpatient Hospital**
  Per admission
  $25.00
- **Outpatient Hospital**
  Per claim (non-emergency service)
  $ 3.40

It is important to note that:

Medicaid beneficiaries cannot be denied services if they are unable to pay the copayment at the time the service is rendered, but this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims to which copayment applies.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

MEDICAID COPAYMENTS (CONT'D.)

Eligibility verification systems will indicate when the beneficiary is exempt from copayment. For those beneficiaries who are not exempt from copayment, it is the provider's responsibility to ascertain if the service is exempt from copayment.

When a beneficiary has Medicare or private insurance, the copayment still applies. However, the amount of the Medicaid copayment plus the Medicare/third-party payment cannot exceed what Medicaid would pay for the service. Hospital providers are reminded that claims involving Medicare and Medicaid will pay the lower of (1) the difference between the Medicaid-allowed amount and the Medicare payment, or (2) the sum of the Medicare coinsurance, blood deductible, and deductible.

1. The collection of copayment is not to be shown in field 54 (Prior Payments); this will result in an additional reduction in payment.
2. For a pregnancy-related service to be exempt from copayment, the primary diagnosis must be the pregnancy.
3. If the service is an emergency, the type of admission in field 14 or the corresponding field on the electronic claim record must be 1, or the claim with revenue code 450 must be reimbursed at the Reimbursement Type 5 level.

Billing Instructions for Service Provided as the Result of an Emergency

If the service was provided as the result of an emergency, providers should utilize the following billing instructions to exempt copayment:

CMS-1500

Providers submitting a professional claim must select "Emergency?" under the Detail Lines tab. For additional information, please refer to the Web Tool User Guide at http://medicaidelearning.com.

UB

Providers submitting a hospital claim must select the appropriate admission source and type under the Additional Information tab. Please refer to the Web Tool User Guide at http://medicaidelearning.com for additional information.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Billing Instructions for Service Provided as the Result of an Emergency (Cont'd.)

DENTAL

Please contact the dental services vendor at 1-888-307-6553 for billing instructions.

COMPLETION OF THE UB-04 CLAIM FORM

Charges for hospital services rendered to a patient are to be billed on the UB-04 claim form. Claims must be sufficiently legible to permit storage on microfilm. Illegible copies will be returned without processing.

Note: All inpatient claims must be submitted for the entire stay. Claims for patients eligible for only part of an admission will be automatically pro-rated.

The National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual can be obtained from:

American Hospital Association
National Uniform Billing Committee - UB-04
PO Box 92247
Chicago, IL 60675-2247

The following fields of the UB-04 are required, or required if applicable, in order for the claim to process. This is not an all-inclusive list. For an all-inclusive list, please refer to the NUBC UB-04 Data Specifications Manual.

Field	Title and Description
1	**PROVIDER NAME AND ADDRESS** Enter the provider name and mailing address.
3A	**PATIENT CONTROL NUMBER** Enter your account number for the beneficiary. The patient account number will be listed as the "OWN REFERENCE NUMBER" on the remittance advice.
3B	**MEDICAL RECORD NUMBER** Enter the number assigned to the patient's medical/health record by the provider. This number is the reference number used by QIO when requesting review samples.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

4 TYPE OF BILL

Medicaid claims must be billed using one of the following bill types:

111 Inpatient hospital, admit through discharge claim

117 Inpatient hospital, replacement claim

118 Inpatient hospital, void/cancel claim

131 Outpatient hospital, admit through discharge claim

137 Outpatient hospital, replacement claim

138 Outpatient hospital, void/cancel claim

141 Outpatient hospital, referenced diagnostic services, admit through discharge claim

147 Outpatient hospital, referenced diagnostic services, replacement claim

148 Outpatient hospital, referenced diagnostic services, void/cancel claim

Interim bill types XX2, XX3, and XX4 may only be used for administrative day claims and must be submitted hard copy to Hospital Services.

5 FEDERAL TAX IDENTIFICATION NUMBER

Enter the facility's federal tax identification number.

6 STATEMENT COVERS PERIOD

Enter the beginning and end dates of the period covered by this bill. Inpatient claims must show the date of admission through the date of discharge. Outpatient claims must show actual date(s) of service. **Outpatient therapy (physical, speech, occupational, audiology), cardiac rehabilitation therapy, chemotherapy, laboratory, pathology, radiology, and dialysis services may be span billed.**

8 A-B PATIENT NAME

Enter the patient's last name, first name, and middle initial.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

9 A-E PATIENT ADDRESS

Enter the patient's complete mailing address (include zip code).

10 PATIENT BIRTH DATE

Enter the month, day, and year of birth of patient in MMDDYYYY format.

11 PATIENT SEX

Enter the sex of the patient:

M – male
F – female

12 ADMISSION DATE

Enter the first day of admission for an inpatient claim in MMDDYY format.

14 ADMISSION TYPE

Enter the code indicating the priority of this inpatient admission:

1 Emergency
2 Urgent
3 Elective
4 Newborn
5 Trauma Center

15 SOURCE OF ADMISSION

Enter the code indicating the source of this admission:

1 Non-Health Care Facility Point of Origin
2 Clinic or Physician's Office
4 Transfer from a Hospital (Different Facility)
5 Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF)
6 Transfer from Another Health Care Facility
8 Court/Law Enforcement
9 Information not Available

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

17 PATIENT STATUS

Enter the patient's status as of the "through" date of the billing period.

01 Discharged to home or self-care (routine discharge)

Usage Note: Status includes discharge to home; home on oxygen if DME only: any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.

02 Discharged/Transferred to a short-term general hospital for inpatient care

03 Discharged/Transferred to a skilled nursing facility (SNF) with Medicare Certification in Anticipation of Skilled Care

04 Discharged/Transferred to a facility that provides custodial or supportive care

Usage Note: Status includes intermediate care facilities (ICFS) if specifically designated at the state level. This status is also used to designate patients that are discharged and/or transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharge and/or transfers to assisted living facilities

05 Discharged and/or transferred to a Designated Cancer Center or Children's Hospital

06 Discharged/Transferred to home under care of an organized home health service organization in anticipation of covered skilled care

07 Left against medical advice or discontinued care

20 Expired

21 Discharged/transferred to Court/Law Enforcement

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

Usage Note: Status includes transfers to incarceration facilities such as jail, prison or other detention facilities.

30 Still patient

62 Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part unit of a hospital

65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66 Discharges/Transfers to a Critical Access Hospital

70 Discharged/transferred to another type of health care institution not defined elsewhere

State Usage Note: Status includes an acute care stay immediately preceding the administrative days.

18-28 CONDITION CODES

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence.

31-34 A-B OCCURRENCE CODES/DATES

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence. Dates must be six digits and numeric. One entry without the other will generate an edit code.

35-36 A-B OCCURRENCE SPAN CODES/DATES

Enter the appropriate codes and dates where one or more occurrences are applicable only if all spaces from 31-34 A-B are filled. If you are entering span dates, both dates must be present.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

39A-41D VALUE CODES/AMOUNTS

Enter both the value code and value amount.

42 REVENUE CODES

Enter the appropriate revenue codes to identify a specific accommodation, ancillary service, or billing calculation. Revenue codes should be entered in ascending order with the **exception of revenue code 001 (total charges), which must always be the last entry.**

43 DESCRIPTION

Enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.

44 HCPCS/RATES

Enter the appropriate HCPCS code applicable to the revenue code on outpatient bills.

45 SERVICE DATE

All revenue code lines on outpatient claims must have a date of service, *i.e.*, MMDDYY.

46 SERVICE UNITS

Enter the number of days or units of service when appropriate for a revenue code. A list of the revenue codes that require units can be found in Section 4.

47 TOTAL CHARGES

Sum the total charges. Enter total charges on the same line as revenue code 001.

48 NON-COVERED CHARGES

Enter the total amount for all non-covered charges.

50A-C PAYER

If Medicaid is the only payer, enter carrier code 619 in field 50A.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

If Medicaid is the secondary or tertiary payer, identify the primary payer on line A and enter Medicaid (619) on line B or C.

Identify all payers by the appropriate three-digit carrier code. A list of carrier codes is located in Appendix 2 of this manual. If a particular carrier or carrier code cannot be found in this manual, providers should visit the Provider Information page on the SCDHHS Web site at http://provider.scdhhs.gov to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the Web site.

54 PRIOR PAYMENTS

Enter the amount received from the primary payer on the appropriate line when Medicaid is secondary or tertiary. Report all primary insurance payments. There will **never** be a prior payment for Medicaid (619).

56 NATIONAL PROVIDER ID (NPI)

Enter the 10-digit NPI.

60 INSURED'S UNIQUE ID

Enter the patient's 10-digit Medicaid ID number on the same lettered line (A, B, or C) that corresponds to the line on which Medicaid payer information was shown in fields 50 - 54.

63 TREATMENT AUTHORIZATION CODE

Enter the assigned authorization number for services that require prior authorization. This number should be entered on the same lettered line (A, B, or C) that corresponds to the Medicaid line (619) in field 50.

64 A-C DOCUMENT CONTROL NUMBER

Enter the claim control number (CCN) of the paid claim when filing a replacement of void/cancel claim. This number should be entered on the A-C line that corresponds to the Medicaid line (619) in field 50.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.

67 PRINCIPAL DIAGNOSIS

Enter the full ICD diagnosis code, when applicable.

The POA indicator will be placed at the eighth position of the diagnosis field. The five reporting options for all diagnosis reporting are as follows:

Y Yes

N No

U No Information in the Record

W Clinically Undetermined

1 Unreported/Not Used – Exempt from POA Reporting

Blank Unreported/not used

Note: Effective January 1, 2011, the number "1" is no longer valid on claims submitted under the version 5010 format for electronic claims.

67 A-Q OTHER DIAGNOSIS CODES

Enter the full ICD diagnosis code, when applicable.

The POA indicator will be placed at the eighth position of the diagnosis field. The five reporting options for all diagnosis reporting are as follows:

Y Yes

N No

U No Information in the Record

W Clinically Undetermined

1 Unreported/Not Used – Exempt from POA Reporting

Blank Unreported/not used

Note: Effective January 1, 2011, the number "1" is no longer valid on claims submitted under the version 5010 format for electronic claims.

73 COUNTY OF RESIDENCE

(Required for State Data Reporting)

Enter the two-digit code that identifies the patient's county of residence.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

74 PRINCIPAL PROCEDURE

On inpatient claims, enter the ICD surgical procedure code that identifies the principal procedure performed and the date on which the principal procedure was performed.

74A-E OTHER PROCEDURE CODES

On inpatient claims, enter the ICD surgical procedure codes for up to five significant procedures other than the principal procedure and the date the procedure was performed.

76 ATTENDING PHYSICIAN ID

Enter the physician's 10-digit NPI.

77-79 OTHER PHYSICIAN ID

Enter the other physician's 10-digit NPI.

81 A-D CODE-CODE OVERFLOW FIELD

Enter value code B3 and a 10-byte taxonomy code.

Revenue Codes That Require Special Coding

A. Revenue Code 110 – Room and Board, Private

When a private room is certified as medically necessary by the attending physician, condition code 39 must be present. If a private room was used, and it was not medically necessary, the difference between the private room rate and the semi-private room rate must be shown in field 48 (non-covered column).

B. Revenue Code 180 – Leave of Absence

Charges for a leave of absence must be shown in the non-covered column (field 48) as well as in the total charges column (field 47). If there are no charges, show 0.00 in the covered and non-covered charge columns.

C. Revenue Codes 510–517, 519, and 761 – Emergency Room, Clinic, and Treatment Room Visits

All outpatient services rendered on the day of the ER/clinic/treatment room visit must be included on the claim. This includes situations where the patient is sent to multiple areas for additional services.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Revenue Codes That Require Special Coding (Cont'd.)

D. Revenue Code 636 – Drugs Requiring Detailed Coding for Outpatient Claims

For outpatient claims this code may be used for the following:

1. Depo-Provera, J1050
2. Vitrasert, J7310
3. Synagis, 90378
4. Implanon, J7307

E. Revenue Code 762 and 769 – Observation Rooms

Observation room charges should be billed as one unit per calendar day. These codes are reimbursed in addition to surgery (Reimbursement Type 1) or non-surgery (Reimbursement Type 5) services. Observation revenue codes **do not** multiply. Reimbursement for observation is subject to recoupment if medical records do not reflect the physician's order.

1. 762, Outpatient Observation. Use this code for patients receiving routine observation room charges.
2. 769, Intensive Observation. Use this code for patients that require more intensive services such as ICU, CCU, or continuous monitoring.

F. Revenue Code 960 - 988 – Professional Fees

Hospital-based physician charges should be listed on the UB-04 using the above revenue codes. However, payment for the professional services is not included in the hospital payment. Refer to the Medicaid Physicians Services Manual for billing information.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

REMITTANCE ADVICE

The Remittance Advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider.

Processed claims and/or lines are assigned one of four statuses in field 10 on the Remittance Advice:

- **Status "P"** – Paid claims or lines
- **Status "S"** – Claims in process that require medical or technical review are suspended pending further action. Provider response is not required for resolution unless it is requested by SCDHHS.
- **Status "R"** – Rejected claims or lines
- **Status "E"** – Encounter data (line contains service provided by the PCP). No action required.

Please refer to the Forms section of this manual for a sample Remittance Advice.

If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. If some lines on the claim have paid and others are rejected, evaluate the reason for the rejection and file a new claim with the corrected information for the rejected lines only, if appropriate. For some rejected claims, it may also be necessary to attach applicable documentation to the new claim for review and consideration for payment.

Note: Corrections cannot be processed from the Remittance Advice.

SCDHHS generates electronic Remittance Advices every Friday for all providers who had claims processed during the previous week. Unless an adjustment has been made, a reimbursement payment equaling the sum total of all claims on the Remittance Advice with status P (paid) will be deposited by electronic funds transfer (EFT) into the provider's account. (See "Electronic Funds Transfer (EFT)" later in this section. Claims that have been submitted to Medicaid for payment and have not appeared on the provider's remittance advice as either paid,

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

REMITTANCE ADVICE (CONT'D.)

suspended, or rejected within 45 days of the date filed should be resubmitted.

Providers must access their Remittance Advices electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool). Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to another provider. Remittance Advices for current and previous weeks are retrievable on the Web Tool.

Suspended Claims

Provider response is not required for resolution of suspended claims unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile. For information regarding your suspended claim, please contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us.

Rejected Claims

For a claim or line that is rejected, edit codes will be listed on the Remittance Advice under the Recipient Name column. The edit code sequence displayed in the column is a combination of an edit type (beginning with the letter "L" followed by "00" or "01," "02," etc.) and a three-digit edit code.

The following three types of edits will appear on the Remittance Advice:

Insurance Edits

These edit codes apply to third-party coverage information. They can stand alone ("L00") or include a claim line number ("L01," "L02," etc.). Always resolve insurance edit codes first.

Claim Edits

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits are prefaced by "L00."

Line Edits

These edit codes are line specific and are always prefaced by a claim line number ("L01," "L02," etc.). They apply to only the line indicated by the number.

The three-digit edit code has associated instructions to assist the providers in resolving their claims. Edit

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Rejected Claims (Cont'd.)

resolution instructions can be found in Appendix 1 of this manual.

If you are unable to resolve an unpaid line or claim, contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for assistance before resubmitting another claim.

Note: Medicaid will pay claims that are up to one year old. If the date of service is greater than one year old, Medicaid will not make payment. The one-year time limit does not apply to retroactive eligibility for beneficiaries. Refer to "Retroactive Eligibility" earlier in this section for more information. Timeliness standards for the submission and resubmission of claims are also found in Section 1 of this manual.

Rejections for Duplicate Billing

When a claim or line is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code on the Remittance Advice under the Recipient Name column (e.g., "L00 852 01/24/14"). This eliminates the need for contacting the PSC for the original reimbursement date.

Claim Reconsideration Policy — Fee-for-Service Medicaid

Effective January 1, 2015, SCDHHS will implement a Claim Reconsideration policy. The Claim Reconsideration process is an informal claim review, and is not a substitute for an appeal of a final agency decision. When requesting a reconsideration, providers must adhere to all applicable policies, timely filing limits, and must comply with the following procedures:

1. Submit a completed SCDHHS-CR Form within 30 days of receipt of the remittance advice reflecting the denial of the claim(s). The SCDHHS-CR Form is located in the Forms section of this provider manual.
2. Complete the SCDHHS-CR Form and attach all documentation in support of your request for reconsideration.

The provider will receive a written response from SCDHHS within 60 days notifying them of the decision of the reconsideration request provided the SCDHHS-CR Form has been fully completed and all supporting documentation was attached for review. If the denial is upheld as a result of the Claim Reconsideration review, the

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

provider has 30 days from receipt of the decision to file an appeal in accordance with the Appeal policy in Section 1 of this provider manual.

Providers should submit Claim Reconsiderations to the following mailing address or fax number:

South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

OR

Fax: 1-855-563-7086

Requests that **do not** qualify for SCDHHS claim reconsiderations:

1. Claim denials resulting from failure to submit documentation during the claim adjudication process do not qualify for a Claim Reconsideration. Providers should submit a new claim and attach documentation.
2. Providers who receive a denial of service for Prior Authorization (PA) through one of SCDHHS contracted agents (*e.g.*, KEPRO, LogistiCare, ICORE, Magellan, DentaQuest) will not qualify for a Claim Reconsideration. The provider must pursue a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.
3. Providers who receive a denied claim or denial of service through one of SCDHHS' Managed Care Organizations (MCOs) must pursue a reconsideration or appeal through the MCO, and will not qualify for a Claim Reconsideration.
4. Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.
5. Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process, and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

If you have any questions regarding this process, please contact the PSC at 1-888-289-0709. For any Medicaid participants enrolled in a managed care plan, the member's MCO is responsible for claims payment and claims redetermination. Please refer all questions regarding claim payment and redeterminations to the Medicaid member's MCO.

EDI Remittance Advice - 835 Transactions

Providers who file electronically using EDI Software can elect to receive their Remittance Advice via the ASC X12 835 (005010X221A1) transaction set or a subsequent version. These electronic 835 EDI Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed. (See Appendix 1 for a listing of CARCs and RARCs.) The electronic 835 EDI Remittance Advice will only report items that are returned with P (paid) or R (rejected) statuses.

Providers interested in utilizing this electronic transaction should contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Duplicate Remittance Advice

Providers must use the Remittance Advice Request Form located in the Forms Section of this manual to submit requests for duplicate remittance advices. Charges associated with these requests will be deducted from a future Remittance Advice and will appear as a debit adjustment. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

Reimbursement Payment

SCDHHS no longer issues hard copy checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer (EFT). (See "Electronic Funds Transfer" later in this section.)

The reimbursement payment is the sum total of all claims on the Remittance Advice with status P. If an adjustment

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Payment (Cont'd.)

request has been completed, it will appear on the Remittance Advice. (See "Claim Adjustments" later in this section.)

Note: Newly enrolled providers will receive a hard copy check until the electronic funds transfer process is successfully completed.

Electronic Funds Transfer (EFT)

Upon enrollment, SC Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

Prior to revoking or revising the EFT authorization agreement, the provider must provide 30 days written notice to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement Form to confirm new and/or updated banking information. Refer to the Forms section for a copy of the EFT Authorization form.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any SC Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

If the bank account cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account. The last four digits of the bank account are reflected on the Remittance Advice. Providers may view their Remittance Advice on the Web Tool for payment information.

When SCDHHS is notified that the provider's bank account is closed or the routing and/or bank account

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Electronic Funds Transfer (EFT) (Cont'd.)

number is no longer valid, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Each time banking information changes, the 15-day pre-certification period will occur and the provider will receive reimbursement via hard copy checks.

Uncashed Medicaid Checks

SCDHHS may, under special circumstances, issue a hard copy reimbursement check. In instances where Medicaid checks to providers remain outstanding 180 days or longer from the date of check issue, SCDHHS is required by federal regulations to refund to the federal government the federal share of those Medicaid checks. Therefore, SCDHHS will have the bank return (or not honor) Medicaid checks presented for payments that are 180 days old or older.

Remittance Advice Items

Listed below is an explanation of each item on the remittance advice. Examples of remittance advice forms with the corresponding items can be found in the Forms section of this manual.

Item	Field and Description
A	**Provider ID** The 10-digit National Provider Identifier (NPI)
B	**Payment Date** Date the provider's check and remittance advice were produced
C	**Provider's Own Reference Number** The patient control number you entered in field 3 on the UB-04. For adjustments, the identification number referenced in your adjustment letter
D	**Claim Reference Number** The claim control number assigned by SCDHHS. Sixteen digits plus an alpha suffix which identifies the claim type: Y and Z for UB-04; or U for adjustments

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
E	**Service Rendered Period** Date(s) of service
F	**Days** The first number indicates the total number of days billed per claim. The second number indicates the total number of days covered by Medicaid.
G	**Amount Billed** Total charges per claim
H	**Title 19 Payment** The total amount paid by Medicaid per claim
I	**Status** The status of the claim processed: **E** = Encounter data (claim contains service provided by the PCP). No action is required. **P** = Paid (claim was submitted correctly) **R** = Rejected (claim contains an edit(s) which must be corrected before payment can be made) **S** = Suspended (claim is being manually reviewed). No action is required at this time. Claim will show up on a future remittance advice with either a P or an R in the status column.
J	**Recipient ID Number** The beneficiary's 10-digit Medicaid identification number
K	**Recipient's Name** Name on the Medicaid file that matches the 10-digit Medicaid identification number in item J.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item **Field and Description**

L **Medicaid Copayment (CO/PY)**

C = $3.00 Outpatient Copayment

D = $25.00 Inpatient Copayment

H = $3.40 Outpatient Copayment

M **Diagnosis Related Group (DRG) – Inpatient Claim Remittance Advice**

The DRG assigned to each **inpatient** claim

M **Outpatient Claim Remittance Advice**

Level/Class (LV/CL)

1. Reimbursement type 1 before July 1, 2004, DOS - class assigned to outpatient surgery
2. Reimbursement Type 1 on or after July 1, 2004, DOS – level/class indication not used
3. Reimbursement type 5 – diagnosis payment level
4. Reimbursement type 4 – not used

Position Indicator (POS/IND)

1. **POS/IND for dates of services on or before September 30, 2015:**

   Reimbursement type 1 before July 1, 2004, DOS – position of the ICD-9 surgical procedure code in fields 80-81 that determined the outpatient surgery payment class

   POS/IND for dates of service on or after October 1, 2015:

   Reimbursement type 1 before July 1, 2004, DOS – position of the ICD-10 surgical procedure code in fields 80-81 that determined the outpatient surgery payment class

2. Reimbursement type 1 on or after July 1, 2004, DOS – position of the HCPCS surgical code in field 44 which determined the outpatient surgery payment rate

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item Field and Description

3. **POS/IND for dates of services on or before September 30, 2015:**

   Reimbursement type 5 position of the ICD-9 diagnosis code which determined the diagnosis payment level

   POS/IND for dates of service on or after October 1, 2015:

   Reimbursement type 5 position of the ICD-10 diagnosis code which determined the diagnosis payment level

4. Reimbursement type 4 – not used

N Type Reimbursement

The specific reimbursement method assigned to claims that have paid. Definitions for reimbursement types are as follows. For formulas and calculations see the Outpatient Fee Schedule on the SCDHHS Web site and Payment Calculations for Hybrid PPS in this section.

Inpatient

A Regular DRG, no outlier, no transfer

B Transfer out, no outlier

C Cost outlier, no transfer

D Day outlier, no transfer

Note: Discontinued for DRG discharges on or after October 1, 2011.

E Transfer out, with cost outlier

F Transfer out, with day outlier

Note: Discontinued for DRG discharges on or after October 1, 2011.

H Partial stay, no outlier

J Partial stay, cost outlier

K Partial stay, day outlier

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item **Field and Description**

Note: Discontinued for DRG discharges on or after October 1, 2011.

M Same day discharge

N Same day discharge with cost outlier

P Per diem, infrequent DRG

Note: Discontinued for DRG discharges on or after October 1, 2011.

Q Per diem, infrequent DRG, over threshold

Note: Discontinued for DRG discharges on or after October 1, 2011.

R Per diem, infrequent DRG, partial

Note: Discontinued for DRG discharges on or after October 1, 2011.

S Per diem, infrequent DRG, partial eligibility, over threshold

Note: Discontinued for DRG discharges on or after October 1, 2011.

T Per diem, infrequent DRG, same day stay

Note: Discontinued for DRG discharges on or after October 1, 2011.

U One day stay

Outpatient

1 Surgery

4 Treatment/Therapy/Testing

5 Non-surgery

O Crossover Indicator (XOV/IND)

Medicare indicated on the claim

P Total Claims

Total number of claims processed on this remittance advice

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
Q	**Total Days** Total number of days covered for claims processed on this remittance advice
R	**Total Amount** Total amount of all charges for claims processed on this remittance advice
S	**Total Payment** Total amount paid for all claims paid on this remittance advice
T	**SCHAP Pg Tot** N/A
U	**SCHAP Total** N/A
V	**Medicaid Page Total**
W	**Medicaid Total** Total amount paid by Medicaid for all claims processed on this remittance advice
X	**Check Total** Total amount for claims processed plus or minus any adjustment made on this remittance advice
Y	**Check Number**
Z	**Provider Name and Address**
AA	**Edits** The reason the claim was rejected **Note:** See Appendix 1 for a description of edits and resolution steps.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item **Field and Description**

BB **Debit Balance Prior to this Remittance**

Amount remaining from a debit adjustment from a previous remittance advice. This amount will be subtracted from this Medicaid payment.

CC **Provider Incentive Credit Amount**

Payments to certain healthcare providers enrolled in special incentive programs.

Claims Adjustments

Adjustments may be initiated by the provider or by SCDHHS staff.

Adjustments will be listed on the last page of the remittance advice. Before the adjustment appears on the remittance advice you will receive a letter notifying you of the adjustment amount, beneficiary(s) name, date(s) of service, and the reason for the adjustment. Each letter will contain an identification number, which will also appear in the "own reference" column of the remittance advice. The identification number will begin with a combination of letters and numbers that identifies the area within SCDHHS that generated the adjustment.

The following list identifies the prefixes and the area within SCDHHS that they represent:

SCDHHS Area Prefixes

ID Prefix	Department
10 _ _ _ _ 11 _ _ _ _ 12 _ _ _ _	Fiscal Affairs ***(submitter code will change yearly to correspond to state fiscal year – 10; 11; 12; 13…)*
AB	Ambulance
ANESTH	Anesthesia Claims Adjustments
C _ _ _ _ _ D _ _ _ _ _ E _ _ _ _ _	MIVS Automated Adjustments **(reason code 12 only)** ***(submitter code alpha character changes yearly – C for SFY '09; D for SFY'10; E for SFY '11; F for SFY'12; G for SFY'13…)*
BNK	Fiscal Affairs – Accounts Receivables (Bankruptcy Providers)
CL	CLTC

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

SCDHHS Area Prefixes

ID Prefix	Department
CHGSPD	Adjustments for Inmate Recovery Claims Processed Incorrectly
CLEMSN	Automated Adjustments for Adjustment Recovery *(Reference number will identify adjustment reason)*
DE	Dental
EA	Contractual & Individual Transportation
EI	Early Intervention
FHSC	First Health POS Adjustments
FRM130	Form 130 Adjustment
H	Claims Resolution - Contract Management
H852	CLTC Adjustment for the SW04006 Cleanup process
HA	Adjustment for Claims Processed Incorrectly
HC	Hospital Crossovers
HD	DME
HH	Home Health
HIT	Bureau of Federal Contracts
HIPCC	Consultation Code Adjustments
HIPCON	Provider Contract Rate Adjustments
HIP837	EDS/HIPAA *(HIPAA – 837 Trans – Provider Initiated Void/Repl Claim)*
HP	Hospice
IA	Speech, Hearing, PT, OT
IC	Acute Care Reimbursements
ID	Pharmacy
IH	Hospitals
IM	Behavioral Health Services
IP	Primary Care
IR	Medical Support Services
IS	Specialty Care
LT	Long Term Care Reimbursement

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

SCDHHS Area Prefixes

ID Prefix	Department
MC	Managed Care Department
MM	Managed Care Enrollment
MX	Fiscal Affairs – Program Recovery & Revenue *(credit balance)*
MS	Office of Medical Services
NB	Fiscal Affairs *(negative balances)*
NH	Nursing Homes
PEPOV	Automated Adjustments for PEP Providers
PI	Program Integrity
R	Fiscal Affairs – Accounts Receivables Accounts Receivables uses reason codes 11, 12 & 19 Financial Systems uses **reason code 18 only***
RB	Care Management – MCO Select Health
RH	Claims Resolution – Contract Management
RS	Ancillary Reimbursement
RX	Claims Resolution – Contract Management *(Nursing Homes/OSS)*

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT

By Reimbursement Type

In these examples, the claims payments are calculated using an estimated per case rate of $8,000.00. The Hospital Specific cost-to-charge ratio is estimated at 33.33% and the DRG relative weights are the actual values effective for discharges on or after October 1, 2011.

REIMBURSEMENT TYPE A - STRAIGHT DRG PAYMENT

Components: Base per case rate $8,000.00
DRG relative weight

Formula: Base rate x DRG relative weight = total payment

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

Examples:

DRG 640-1 relative weight				0.1005			
$8,000.00	x	0.1005			=	$804.00	(payment for this claim)
DRG 560-1 relative weight				0.3115			
$8,000.00	x	0.3115			=	$2,492.00	(payment for this claim)

REIMBURSEMENT TYPE B - TRANSFER PAYMENT

Components:

Base rate $8,000.00
DRG relative weight
Average of length stay (ALOS) for DRG
Length of stay (LOS)

Formula: Base rate x DRG relative weight / ALOS x LOS = transfer payment

Examples:

TRANSFER LOS LESS THAN ALOS

DRG 640-1 relative weight				0.1005			
LOS				1	day		
ALOS				2.120	days		
$8,000.00	x	0.1005			=	$804.00	(base payment)
$804.00	/	2.120	x	1	=	$379.25	(payment for this claim)

TRANSFER LOS GREATER THAN ALOS

DRG 640-1 relative weight				0.1005			
LOS				12	days		
ALOS				2.120	days		
$8,000.00	x	0.1005			=	$804.00	(base payment)
$804.00	/	3.466	x	12	=	$2,783.64	(transfer payment)
Lesser of Base or Transfer					=	$804.00	(payment for this claim)

Note: The transfer payment cannot exceed the base payment for the DRG.

REIMBURSEMENT TYPE C - COST OUTLIER

Components:

Base rate
DRG relative weight
Hospital Specific Cost / Charge Ratio (HSCCR)
Cost outlier threshold for DRG
Allowed charges (total claim charges - non-covered charges)
Cost outlier percentage (%)
Base payment
Cost outlier payment

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

Formula: Base rate x DRG relative weight = base payment
[(HSCCR x allowed charges) - (cost outlier threshold+DRG base payment)] x cost outlier % = cost outlier payment
Base payment + cost outlier payment = total payment

Examples:

DRG 640-1 relative weight	0.1005
Allowed charges	$125,972
HSCCR	0.3333
Cost outlier %	60%
Cost outlier threshold	$30,000

$8,000.00	x	0.1005	=	$804.00	(base payment)
[(.3333 x $125,972)		+$30,000-$804.00] x 60%	=	$6,709.48	(cost outlier payment)
$804.00	+	$6,709.48	=	$7,513.48	(payment for this claim)

REIMBURSEMENT TYPE E - TRANSFER WITH COST OUTLIER

Components:
Base rate 8,000.00
DRG relative weight
Base payment
Hospital Specific Cost / Charge Ratio (HSCCR)
ALOS for DRG
LOS
Transfer payment
Cost outlier threshold for DRG
Cost outlier %
Allowed charges (total charges - non-covered charges)

Formula: Base rate x DRG relative weight / ALOS x LOS = transfer payment
[(HSCCR x allowed charges) - cost outlier threshold-transfer payment] x cost outlier % = cost outlier payment
Transfer payment + cost outlier payment = total payment

Note: Transfer payment cannot exceed base payment.

Example:

DRG 640-1 relative weight	0.1005	
SWCCR	0.3333	
ALOS	2.120	days
LOS	2	days
Cost outlier threshold	$30,000	
Allowed charges	$187,965	
Cost outlier %	60%	

$8,000.00	x	0.1005	=	$804.00	(base payment)
($804.00/ 2.12) x 2			=	$758.49	(transfer payment)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

[(.3333 x $187,965) - $30,000-758.49] x 60%			=	$19,134.15	(cost outlier payment)
$758.49	+	$19,134.15	=	$19,892.64	(payment for this claim)

REIMBURSEMENT TYPE H - PARTIAL ELIGIBILITY

Components:
Base rate $8,000.00
DRG relative weight
Recipient's beginning eligibility date (02/01/09)
LOS/dates of service (01/25/09-02/5/09)
Covered days
Covered days % (covered days/LOS)

Formula: Base rate x DRG relative weight x covered days % = total payment

Example:

DRG 640-1 relative weight		0.1005			
LOS		11	days		
Covered days		4	days		
Covered days %		0.363636			
$8,000.00	x 0.1005	x 0.363636	=	$292.36	(payment for this claim)

REIMBURSEMENT TYPE J - PARTIAL ELIGIBILITY WITH COST OUTLIER

Components:
Base rate $8,000.00
DRG relative weight
LOS/dates of service (01/25/11-02/05/12)
Covered days
Recipient's beginning eligibility date (02/01/11)
Covered days % (covered days/LOS)
Base payment
Cost outlier threshold
Cost outlier %
Cost outlier payment
Allowed charges
HSCCR
Adjusted cost (allowed charges x HSCCR)
Cost over the threshold (adjusted cost - cost outlier threshold)

Formula:
Base rate x relative DRG weight = base payment
[(allowed charges x HSCCR) - (cost outlier threshold+DRG base payment] x cost outlier % = cost outlier payment
(Base payment + cost outlier payment) x covered days % = total payment

Example:

DRG 640-1 relative weight	0.1005
HSCCR	0.3333

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

LOS				11	days		
Covered days				4	days		
Covered days %				0.363636			
Cost outlier threshold				$30,000			
Allowed charges				$187,965			
Cost outlier %				60%			
$8,000.00	x	0.1005			=	$804.00	(base payment)
$187,965.00	x	0.3333			=	$62,648.73	(adjusted cost)
$62,648.73	-	$30000-$804	x	60%	=	$19,106.84	(cost outlier payment)
($804	+	$19,106.84)	x	0.363636	=	$7,240.31	(payment for this claim)

REIMBURSEMENT TYPE M - SAME DAY DISCHARGE/HALF PER DIEM

Components: Base rate $8,000.00
DRG relative weight
ALOS for DRG
Half day rate

Formula: (Base rate x DRG relative weight) / ALOS x 50% = total payment

Example:

DRG 420-1 relative weight				0.3969			
ALOS				2.710			
Half day rate				50%			
$8,000.00	x	0.3969			=	$3,175.20	(base payment)
$3,175.20	/	2.710	x	50%	=	$585.83	(payment for this claim)

Note: All same day discharges are paid at half the single day DRG payment except normal deliveries, false labor , normal newborn , and deaths.
These exception DRGs receive the whole DRG payment.
Same day transfers are paid under the transfer payment methodology.

REIMBURSEMENT TYPE N - SAME DAY DISCHARGE WITH COST OUTLIER

Components: Base rate $8,000.00
DRG relative weight
Base payment
ALOS for DRG
Allowed charges
Cost outlier threshold for DRG
HSCCR
Cost outlier %
Adjusted cost (allowed charges x HSCCR)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

Adjusted base payment
Cost outlier payment

Formula: (Base rate x DRG relative weight) / ALOS x 50% = adjusted base payment
[(Allowed charges x HSCCR) - cost outlier threshold-adj base pay] x cost outlier % = cost outlier payment
Adjusted base payment + cost outlier payment = total payment

Example:

DRG 420-1 relative weight		0.3969			
ALOS for DRG		2.710			
Half day rate		50%			
HSCCR		0.3333			
Covered charges		$187,965			
Cost outlier threshold		$30,000			
Cost outlier %		60%			
$8,000.00	x	0.3969	=	$3,175.20	(base payment)
($3,175.20 / 2.71) x 50%			=	$585.83	(adjusted payment)
[($187,965 x .3333) - $30,000-585.83] x 60%			=	$19,237.74	(cost outlier payment)
$585.83	+	$19,237.74	=	$19,823.57	(payment for this claim)

REIMBURSEMENT TYPE U - ONE-DAY STAY

Components: Base rate $8,000.00
DRG relative weight
Dates of service
ALOS

Formula: Base rate x DRG relative weight / ALOS = total payment

Example:

DRG 420-1 relative weight				0.3969			
ALOS				2.710			
$8,000.00	x	0.3969	/	2.710	=	$1,171.66	(payment for this claim)

Note: Exceptions are Normal Delivery, False Labor, Normal Newborn, and Deaths. These receive the full DRG payment.
Transfers are paid under the transfer payment methodology.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Claims with Third-Party Payments

A. TPP and Full Eligibility

The system compares TPP to Medicaid's payment. If TPP is greater than or equal to Medicaid's payment, then no payment is due from Medicaid.

If TPP is less than Medicaid's payment, Medicaid pays the difference up to the Medicaid payment amount.

B. TPP and Partial Eligibility

If partial eligibility occurs, the system compares the TPP to the non-eligible portion of the Medicaid payment. If the TPP is greater than the non-eligible portion, then the difference between the TPP and the non-eligible portion will be subtracted from the Medicaid payment.

If the TPP is less than or equal to the non-eligible portion, the TPP will not be subtracted from the Medicaid payment.

COST AVOIDANCE (THIRD-PARTY LIABILITY)

Under the cost avoidance process, specific claim fields are matched against information contained in third-party liability (TPL) files. If third-party liability records indicate insurance coverage that was not indicated on the claim, or if the claim was improperly coded, claims will receive one or more TPL edits.

Providers should not submit claims until payment or notice of denial is received from all liable third parties. **However, the Medicaid claims filing deadline cannot be extended on the basis of third-party liability requirements.**

If a claim or line is rejected for primary payer(s) or failure to bill third-party coverage, providers should submit a new claim and include the insurance carrier code, the policy number, and the name of the policyholder found in third-party payer information on the Web Tool. Information about the insurance carrier address and telephone number may be found in Appendix 2 of this manual. Providers can also view carrier codes on the Provider Information page at http://provider.scdhhs.gov.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reporting Third-Party Insurance on a UB-04 Claim Form

To indicate that a claim has been submitted to a liable third party, code the three-digit carrier code (representing the name of the insurance company), the policy number, and the amount paid according to the following instructions:

Note: All insurance policy information must be entered on the same lettered A, B, or C line that corresponds to the payer information in fields 50, 54, and 60.

Field 50 (mandatory field)

Enter the valid third-party three-digit carrier code. A list of valid carrier codes can be found in the UB manual. Do not write the name of the corresponding carrier. It will generate a TPL edit.

Field 54 (mandatory field)

Enter the insurance payment amount. If no payment was received, follow the additional directives for field 54 below, to code a denial. When the third-party payment is greater than or equal to the Medicaid-allowed amount, Medicaid will not pay any remaining balance on the claim. The Medicaid beneficiary is not liable for the balance.

Field 54 (mandatory field)

Indicate insurance denial by coding 0.00 in this field. Enter occurrence code 24 and the date of denial in field 31-34 A-B.

Field 60 (mandatory field)

Enter the policy number corresponding to the carrier code indicated in field 50. If Medicaid TPL policy records indicate a carrier code plus policy number in contrast to information reported on the claim, edit 150 will be generated. (Hint: Avoid edit code 150 by omitting the three-digit alpha prefix for State Group (cc400) and BCBSSC (cc401) plans when coding insurance on Medicaid claims. However, be sure to include the alpha prefix when filing directly to State Group or BCBSSC. Blue Cross and Blue Shield of SC requires the alpha prefix.)

Attach notice of payment or denial to a new hard copy claims. If documentation is attached, TPL staff will review insurance edits prior to approving or rejecting any claim. Insurance documentation is required to resolve any TPL edit received once a claim has been rejected.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reporting Third-Party Insurance on a UB-04 Claim Form (Cont'd.)

Generally, if insurance is coded correctly, claims will not receive a TPL edit. The exception is the following situation:

- There are potentially three or more carriers on record. The claim will receive edit code 151. Call the PSC or submit an online inquiry to ensure all occurrences of insurance have been identified. Attach EOBs for all carriers to a new claim and return to Medicaid Claims Control Services.

Casualty Cases

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the beneficiary's attorney or the casualty insurance carrier, or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then SCDHHS will pursue reimbursement from any liable third party.

For casualty cases, you may bill Medicaid any time before the one-year limit for submitting a claim. These claims will process without denial from the third party by entering CAS in field 50 and entering a policy number, carrier name, or an attorney's name in field 60. Enter occurrence code 24, the accident date, and 0.00 in field 54. Once the provider bills Medicaid, the Medicaid payment is payment in full. Medicaid will pursue the settlement payment.

Retro Medicare

Every month, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage (Retro Medicare). The letter provides the beneficiary's Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Retro Medicare (Cont'd.)

accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5, then option 1.

Where claims have been pulled into Retro Medicare and Retro Health for institutional providers, the provider should not attempt to refund the claim with a void or void/replacement claim. Should they do so, they will incur edits 561, 562, and 563.

Retro Health

Where SCDHHS discovers a primary payer for a claim Medicaid has already paid, SCDHHS will pursue recovery. Once an insurance policy is added to the TPL policy file, claims that have services in the current and prior calendar years are invoiced directly to the third party.

As new policies are added each month to the TPL policy file, claims history is reviewed to identify claims paid by Medicaid for which the third party may be liable. A detailed claims listing is generated and mailed to providers in a format similar to the Retro Medicare claims listing. The listing identifies relevant beneficiaries, claim control numbers, dates of service, and insurance information. Three notices over a period of three months are provided. Claims will be recouped approximately 90 days after the first letter if no response is received. If you have questions about this process, please contact Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5, then option 1.

TPL Refunds

When reimbursed by both Medicaid and third-party insurance, the provider must refund either the amount paid by Medicaid or the full amount by the insurance company, whichever is less. Refer to "Refunds" in this section for refund information.

Solutions to TPL Problems

If the third-party insurance refuses to send a written denial or explanation of benefits, you may file the claim as a denial accompanied by reasonable effort documentation.

When the insurance company will not process the claim without a beneficiary's signature, and the beneficiary cannot be found or is uncooperative, the claim may be filed as a denial accompanied by reasonable effort documentation. Complete the reasonable effort document

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Solutions to TPL Problems (Cont'd.)

detailing your attempts to contact the beneficiary to obtain the information. Use condition code 08 in fields 18-28 to indicate an uncooperative beneficiary. Send the reasonable effort documentation with a new correctly coded claim to Medicaid Claims Processing.

If the third-party insurance pays the beneficiary and not the provider, the provider may bill the beneficiary up to the amount of the insurance payment. If the provider cannot collect from the beneficiary, the claim may be filed to Medicaid within the timely filing limits as a denial accompanied by a reasonable effort document.

The reasonable effort document must demonstrate sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or beneficiary. A reasonable effort document can be found in the Forms section of this manual. If filing hard copy claim, attach the reasonable effort document to the corrected claim and return to Medicaid Claims Processing.

A Health Insurance Referral Form should be used to notify SCDHHS when a beneficiary's insurance policy has lapsed, or when a beneficiary has an insurance policy that SCDHHS does not have on file. A Health Insurance Referral Form is provided in the Forms section of this manual. Attach any written documentation that supports the reason for the Referral Form and return to the address on the form. If information was researched by telephone, provide as much detail as possible to facilitate TPL research.

Medicaid is considered the payer of last resort. The following programs are some exceptions to the payer of last resort mandate: BabyNet, Best Chance Network, Black Lung, Community Health, Crime Victims Compensation Fund, CRS Children's Rehabilitative Services, DHEC Family Planning (DHEC Maternal Child Health), Indian Health, Migrant Health, Ryan White Program, State Aid Cancer Program, Vaccine Injury Compensation, Veterans Administration, and Vocational Rehabilitation Services.

ADMINISTRATIVE DAYS CLAIMS

When a beneficiary's acute care is terminated, the hospital should administratively discharge the patient. The acute care claim (bill type 111) should show this termination date as the date of discharge and 70 in field 17 for the patient's status. This bill for the acute care stay may be transmitted electronically.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

ADMINISTRATIVE DAYS CLAIMS (CONT'D.)

Medicaid beneficiaries who are eligible for administrative days can begin their administrative day coverage with the date of the acute care discharge. Dually eligible beneficiaries (Medicare/Medicaid) should begin administrative days coverage after the Medicare three-day grace period. Please refer to Administrative Days in Section 2 for program policies and procedures.

Claims for administrative days must be submitted hard copy. Claims must be billed monthly (calendar month) and are paid a per diem rate. The per diem rate is an all-inclusive payment for room and board, drugs, and supplies. Ancillary services rendered to patients in administrative days may be billed under the hospital outpatient number and will be reimbursed according to the outpatient fee schedule.

There are two reimbursement rates for administrative days depending on the level of service. The following table lists the two reimbursement types with Medicaid rates.

Reimbursement Type	Dates of Service	Medicaid Rate
Routine	October 1, 2010 – April 7, 2011	$163.83
	April 8, 2011 – October 31, 2011	$158.92
	November 1, 2011 – Present	$159.42
Ventilator Dependent	December 8, 2008 – April 7, 2011	$364.00
	April 8, 2011 – September 30, 2011	$353.08
	October 1, 2011 – Present	$450.00

Administrative days rates are established based on the average nursing home rate plus the alternative reimbursement methodology rate for drugs. New rates are usually effective with date(s) of service on or after October 1 of each year.

Billing Notes

The administrative days program follows the Medicaid policy on time limits for submitting claims. Required documentation and applicable TPL information must be attached to the claim. All claims for administrative days must be submitted hard copy to the following address:

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Billing Notes (Cont'd.)

SCDHHS
Division of Hospital Services
Attn: Administrative Days Program Representative
Post Office Box 8206
Columbia, SC 29202-8206

Initial Administrative Days Claims

The following information must be submitted:

1. A hard copy UB-04 claim with only the charges reimbursed under the administrative day program, *i.e.*, room and board, drugs, and supplies. Revenue code 100 (all inclusive rate) must be used.
2. The Community Long Term Care level of care certification letter (DHHS Form 185 or 171)
3. The notification of administrative days coverage letter
4. Documentation that supports the weekly bed search
5. HINN letter or documentation of date when Medicare benefits were exhausted for dually eligible beneficiaries

Subsequent Administrative Days Claims

The following documentation must be submitted:

1. A statement indicating the unavailability of a nursing home bed on a **monthly** basis. Documentation to support a weekly nursing home bed search should be kept in the patient's medical record or on another form.

UB-04 Data Fields

The following lists the pertinent data fields that must be completed when billing for administrative days:

ADMINISTRATIVE DAYS DATA FIELDS		
Field 4	Bill Type	112 (initial bill), 113 (interim bill(s), 114 (final bill), or 111 (if bill is the first and last)
Field 6	Statement Covers Period	Date of billing cycle (by calendar month)
Field 12	Admission Date	Date administrative days began
Field 17	Status	31 if assessment is skilled 32 if assessment is intermediate

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

ADMINISTRATIVE DAYS DATA FIELDS		
Field 42	Revenue Codes	Only use revenue code 100
Field 54	Prior Payment	Any TPL payment
Field 56	National Provider Identifier	10-digit NPI number
Field 67	Principal Diagnosis	For dates of service on or before **September 30, 2015**: V63.2 (person awaiting admission to adequate facility elsewhere) For dates of service on or after **October 1, 2015**: Z75.1 (person awaiting admission to adequate facility elsewhere)
Fields 67 A-Q	Other Diagnoses	All pertinent diagnosis codes
Field 80	Remarks	**If appropriate, note "ventilator dependent" or if the patient returned to acute care.**
Field 81	CC (Code Code)	Qualifying code "B3" for taxonomy and 10-digit taxonomy code

Ancillary Services

During administrative days, ancillary services may be billed using bill type 131 under the hospital's NPI. The taxonomy code must be listed in field 81 for hospital with two or more outpatient provider numbers. Payment will be made according to the outpatient fee schedule. These claims may be transmitted electronically or sent hard copy to the Medicaid claims receipt address.

Ancillary charges for dually eligible beneficiaries should be billed to Medicare. Medicaid will pay the applicable deductible and/or coinsurance amounts.

Cost Avoidance

Administrative day claims are subject to third-party regulations. Claims for patients who have skilled nursing home insurance must first be submitted to the carrier; otherwise, they will reject.

Medicare pays for skilled care in a hospital setting up to the limit of 150 days (including lifetime reserve days). Medicaid will pay for administrative days for skilled dually eligible patients once Medicare benefits are exhausted.

SECTION 4
BILLING CODES

TABLE OF CONTENTS

Note: ICD-9 codes for dates of service on or before **September 30, 2015** are located on the SCDHHS website on the Hospital Services Provider Manual webpage.

SECTION 4
BILLING CODES

TABLE OF CONTENTS

SECTION 4 BILLING CODES

OUTPATIENT FEE SCHEDULE: REIMBURSEMENT TYPES

The outpatient fee schedule is designed to reimburse for actual services rendered. Only one category of service, based on the highest classification billed, is paid per claim; however, each category can include an additional reimbursement for clinical lab services plus add-ons or the total S.C. Medicaid allowed amount, whichever is less.

REIMBURSEMENT TYPE 1 – SURGICAL

UB-04 must show all charges associated with the surgery. CPT surgical codes have been assigned an all-inclusive rate that is comparable to the procedure performed and resources used. Multiple surgeries pay the highest reimbursement amount. A listing of the CPT surgical codes and their reimbursement amounts can be found at **www.scdhhs.gov**.

The following are the **only** services paid in addition to the all-inclusive rate for reimbursement type 1:

762-Observation
769-Intensive Observation
636 w/J1050-Depo-Provera
636 w/J7310-Vitrasert
636 w/90378-Synagis
636 w/J7307- Implanon
636 w/J7296 Kyleena
636 w/J7297- Liletta
636 w/J7298- Mirena
636 w/J7300- Paragard
636 w/J7301- Skyla
636 w/A4264 - Essure, permanent implantable contraceptive intra-tubal occusion device(s) and delivery system (Essure)*

*This add-on service requires a Consent for Sterilization form to be signed 30 days prior to the procedure.

REIMBURSEMENT TYPE 5 – NON-SURGICAL

Revenue code 450 pays an all-inclusive rate based on the diagnosis code level. Multiple diagnosis codes pay the highest reimbursement level. A listing of the diagnosis codes by outpatient reimbursement levels can be found at **www.scdhhs.gov**.

Level 1-$ 70.48
Level 2-$126.86
Level 3-$270.16

Revenue codes 510, 511, 512, 513, 514, 515, 516, 517, 519 or 761 pay an all-inclusive rate based on Level 1 (Non-emergent) regardless of the diagnosis codes.

The following are the **only** services paid in addition to the all-inclusive rate for reimbursement type 5. (Add-ons are not allowed to the reimbursement for revenue code 451, EMTALA screening):

762-Observation
769-Intensive Observation

SECTION 4 BILLING CODES

OUTPATIENT FEE SCHEDULE: REIMBURSEMENT TYPES

636 w/J1050-Depo-Provera
636 w/J7310-Vitrasert
636 w/90378-Synagis
636 w/J7307- Implanon
636 w/J7296 Kyleena
636 w/J7297- Liletta
636 w/J7298- Mirena
636 w/J7300- Paragard
636 w/J7301- Skyla
636 w/A4264- Essure, permanent implantable contraceptive intra-tubal occusion device(s) and delivery system (Essure)*

*This add-on service requires a Consent for Sterilization form to be signed 30 days prior to the procedure.

Revenue code 451 pays an all-inclusive rate of $58.73 for an emergency room screening under the Federal EMTALA guidelines based on valid diagnosis code.

REIMBURSEMENT TYPE 4 – TREATMENT/THERAPY/TESTING

Revenue Codes That Require Procedure Codes	Revenue Codes That Do Not Require Procedure Codes with Fee Schedule Amounts	
300	170, 171 – Nursery	$ 483.94
301	258 – IV Solutions*	$ 61.08
302	260, 261 – IV Therapy*	$ 58.73
304	331 – Chemotherapy – Inject*	$ 490.99
305	332 – Chemotherapy – Oral*	$ 162.09
306	335 – Chemotherapy – IV*	$ 162.09
307	380,381,382, 383, 384, 385, 386, 387 – Blood*	$ 61.08
309	390 – Blood Storage	$ 79.87
310	391 – Blood Administration	$ 51.69
311	410 – Respiratory Services*	$ 49.34
312	412 – Inhalation Services	$ 54.03
314	413 – Hyperbaric Oxygen	$ 178.55
319	419 – Other Respiratory	$ 44.64
320	420 – Physical Therapy* †	$ 49.34
321	424 – PT Evaluation*†	$ 49.34
322	430 – Occupational Therapy*†	$ 49.34
323	434 – OT Evaluation*†	$ 49.34
324	440 – Speech Therapy*†	$ 54.59
329	444 – Speech Evaluation*†	$ 77.52
330	459 – Other ER (PEP Triage)	$ 58.73
333	460, 469 – Pulmonary Function	$ 434.61
340	470, 472, 479 – Audiology	$ 434.61
341	471 – Audiology/Diagnostic	$ 483.94
342	480, 483, 489 – Cardiology	$ 244.32
343	481 – Cardiac Cath Lab	$ 728.26
349	482 – Cardiac Stress Test	$ 145.65
350	636 w/J1050 – Depo-Provera	$ 43.50
351	636 w/J7310 – Vitrasert	$17,600.00
352	636 w/90378 – Synagis* - 50 mg $1161.31 and 100mg	$2192.89
359	636 w/J7307 – Implanon	$ 615.04
400	721 – Labor Room	$ 70.48
401	730, 739 – EKG/ECG	$ 119.81
402†	731 – Holter Monitor	$ 434.61
403	732 – Telemetry	$ 256.07
404	740, 749 – EEG	$ 256.07
420	750, 759 – Gastro Intestinal Svcs	$ 434.61

SECTION 4 BILLING CODES

OUTPATIENT FEE SCHEDULE: REIMBURSEMENT TYPES

424†	762 – Observation	$ 244.32
430†	769 – Intensive Observation	$ 364.13
434†	820, 821, 830, 831, 840, 841, 850, 851 – Dialysis Services*	$ 291.30
440†	900 – Psychiatric Treatment*	$ 84.57
444†	901 – Electroshock Therapy	$ 223.18
610	910 – Psychiatric Services*	$ 89.27
611	914 – Individual Therapy*	$ 49.34
612	915 – Group Therapy*	$ 44.64
614	916 – Family Therapy*	$ 49.34
615	918 – Psychiatric Testing	$ 49.34
616	920 – Other Diagnostic Services	$ 145.65
618	921 – Peripheral Vascular	$ 453.40
619	922 – Electromyelogram	$ 86.92
634	924 – Allergy Test	$ 70.48
635	929 – Other Diagnostic Services*	$ 162.09
636	940 – Other Therapeutic Services	$ 115.12
923	943 – Cardiac Rehab Therapy*	$ 54.03

* Pays listed rate for each unit of service billed.

† Revenue code requires CPT code as of 6/1/12

SECTION 4 BILLING CODES

OUTPATIENT FEE SCHEDULE: REIMBURSEMENT TYPES

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SECTION 4 BILLING CODES

REVENUE CODES

COVERED SERVICE INDICATOR
0 Not covered
1 Inpatient & outpatient covered
2 Inpatient only
3 Outpatient only
4 Inpatient covered/outpatient by procedure

UNITS/ROOM INDICATOR
0 Units not required
1 Routine care units required
2 Units required
3 Nursery accommodation units required
4 Units required on outpatient only
5 Neonatal units required
6 Special care units required

Revenue Code	Description	Covered Service	Units/ Room
001	TOTAL CHARGE	1	0
100	ALL INCLUSIVE RATE	2	1
101	ALL INC R&B	0	0
110	ROOM & BOARD - PRIVATE MED. OR G	2	1
111	MED-SUR-GY/PVT	2	1
112	OB/PVT	2	1
113	PEDS/PVT	2	1
114	PSYCHIATRIC PRIVATE R&B	2	1
115	HOSPICE/PVT	2	1
116	DETOX PRIVATE ROOM AND BOARD	2	1
117	ONCOLOGY PRIVATE ROOM AND BOA	2	1
118	ROOM AND BOARD PRIVATE REHABI	2	1
119	OTHER/PVT	2	1
120	ROOM & BOARD - SEMI-PRIVATE TWO	2	1
121	MED-SUR-GY/2BED	2	1
122	OB/2BED	2	1
123	PEDS/2BED	2	1
124	PSYCHIATRIC SEMI PRIVATE R&B	2	1
125	HOSPICE/2BED	2	1
126	DETOX SEMI PRIVATE ROOM AND BO	2	1
127	ONCOLOGY SEMI PRIVATE ROOM AN	2	1
128	ROOM AND BOARD SEMI-PRIV WO BE	2	1
129	OTHER/2BED	2	1

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
130	SEMI-PRIVATE - THREE AND FOUR BE	2	1
131	MED-SUR-GY/3&4BED	2	1
132	OB/3&4BED	2	1
133	PEDS/3&4BED	2	1
134	PSYCHIATRIS SEMI PRIVATE 3&4 BED	2	1
135	HOSPICE/3&4BED	2	1
136	DETOX SEMI PRIVATE 3&4 BEDS	2	1
137	ONCOLOGY/3&4BED	2	1
138	SEMI-PRIV (3 OR 4 BEDS) REHABILITA	2	1
139	OTHER/3&4BED	2	1
140	PRIVATE (DELUXE)	2	1
141	MED-SUR-GY/PVT/DLX	0	0
142	OB/PVT/DLX	0	0
143	PEDS/PVT/DLX	0	0
144	PSYCHIATRIC PRIVATE DELUX	0	0
145	HOSPICE/PVT/DLX	0	0
146	DETOX PRIVATE ROOM DELUXE	0	0
147	ONCOLOGY/PVT/DLX	0	0
148	PRIVATE (DELUXE)REHABILATION	0	1
149	OTHER/PVT/DLX	0	0
150	ROOM & BOARD WARD (MED. OR GEN	2	1
151	MED-SUR-GY/WARD	2	1
152	OB/WARD	2	1
153	PEDS/WARD	2	1
154	PSYCHIATRIC WARD	2	1
155	HOSPICE/WARD	2	1
156	DETOX WARD	2	1
157	ONCOLOGY/WARD	2	1
158	ROOM AND BOARD WARD (M&D OR G	2	1
159	OTHER/WARD	2	1
160	OTHER ROOM & BOARD GENERAL	2	1
164	OTHER ROOM & BOARD - STERILE EN	2	1

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
167	CHRGS INCRD BY PROV-NONINSTITU	0	1
169	R&B/OTHER	2	1
170	NURSERY	1	3
171	NURSERY-LEVEL I	1	3
172	NURSERY LEVEL II	2	5
173	NURSERY-LEVEL IIE	2	5
174	NURSERY-LEVEL III	2	5
179	NURSERY OTHER	0	0
180	LEAVE OF ABSENCE	0	1
182	LOA/PT CONV	0	1
183	LEAVE OF ABSENCE THERAPEUTIC	0	1
184	LOA/ICF/MR	0	1
185	LOA/NURS HOME	0	1
189	LOA/OTHER	0	1
200	INTENSIVE CARE	2	6
201	ICU/SURGICAL	2	6
202	ICU/MEDICAL	2	6
203	ICU/PEDS	2	6
204	INTENSIVE PSYCHIATRIC CARE	2	6
206	POST ICU	2	6
207	INTENSIVE BURN UNIT	2	6
208	ICU/TRAUMA	2	6
209	ICU/OTHER	2	6
210	CORONARY CARE	2	6
211	CCU/MYO INFARC	2	6
212	CCU/PULMONARY	2	6
213	CCU/TRANSPLANT	2	6
214	POST CCU	2	6
219	CCU/OTHER	2	6
220	SPECIAL CHARGES	0	0
221	ADMIT CHARGE	0	0
222	TECH SUPPORT CHARGE	0	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
223	UR CHARGE	0	0
224	LATE DISCHARGE MEDICALLY NECES	2	1
229	OTHER SPEC CHARGE	0	0
230	NURSING ACUITY	2	0
231	NUR INCR/NURSERY	2	0
232	NUR INCR/OB	2	0
233	NUR INCR/ICU	2	0
234	NUR INCR/CCU	2	0
235	NUR INCR/HOSPICE	2	0
239	NUR INCR/OTHER	2	0
240	ALL INCL ANCIL	0	0
249	ALL INCL ANCIL-OTHER	0	0
250	PHARMACY - GENERAL	1	0
251	DRUGS/GENERIC	1	0
252	DRUGS/NONGENERIC	1	0
253	TAKE HOME DRUGS	2	0
254	DRUGS INCIDENT TO OTH DIAG SERV	1	0
255	DRUG INCIDENCE TO RADIOLOGY	1	0
256	EXPERIMENTAL DRUGS	0	0
257	DRUGS/NONSCRPT	1	0
258	PHARMACY-IV SOLUTIONS	1	2
259	DRUGS OTHER	1	0
260	IV THERAPY	1	4
261	IV THERAPY/INFUSION	1	4
262	IV THER-PHARM-SVC	0	0
263	IV THER-DRUG-SPPLY DELV	0	0
264	IV THER-SUPPLIES	0	0
265	EXPERIMENTAL	0	0
269	IV THER-OTHER	0	0
270	MEDICAL/SURGICAL SUPPLIES AND D	1	0
271	NON-STERILE SUPPLIES	1	0
272	STERILE SUPPLIES	1	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
273	TAKE HOME SUPPLY	0	0
274	PROSTETIC DEVICE	1	0
275	PACEMAKER	1	0
276	INTRAOCULAR LENS	1	0
277	OXYGEN TAKE HOME	0	0
278	OTHER IMPLANTS	1	0
279	OTHER SUPPLIES AND/OR DEVICES	1	0
280	ONCOLOGY	0	0
289	ONCOLOGY OTHER	0	0
290	DURABLE MEDICAL EQUIPMENT - GE	0	0
291	DURABLE MEDICAL EQUIPMENT - RE	0	0
292	PURCHASE NEW	0	0
293	DME PURCHASED USED	0	0
294	MED EQUIP-SUPPLIES-DRUGS	0	0
299	DURABLE MEDICAL EQUIPMENT - OT	0	0
300	LABORATORY - GENERAL	4	4
301	LAB/CHEMISTRY	4	4
302	LAB/IMMUNOLOGY	4	4
303	LABORATORY RENAL PATIENT (HOM)	0	0
304	LABORATORY - NON-ROUTINE DIALY	4	4
305	LAB/HEMATOLOGY	4	4
306	LAB/BACT-MICRO	4	4
307	LAB/UROLOGY	4	4
309	LAB/OTHER	4	4
310	LABORATORY PATHOLOGICAL	4	4
311	PATHOLOGY/CYTOLOGY	4	4
312	PATHOLOGY/HYSTOLOGY	4	4
314	PATHOL/BIOPSY	4	4
319	PATHOL/OTHER	4	4
320	RADIOLOGY - DIAGNOSTIC	4	4
321	DX X-RAY/ANG	4	4
322	DX X-RAY/ART	4	4

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
323	ARTERIOGRAPHY	4	4
324	CHEST XRAY	4	4
329	DX X-RAY/OTHER	4	4
330	RADIOLOGY - THERAPEUTIC	4	4
331	CHEMOTHERAPY-INJECTED	1	2
332	CHEMOTHERAPY-ORAL	1	2
333	RADIATION THERAPY	4	4
335	CHEMOTHERAPY-IV	1	2
340	NUCLEAR MEDICINE	4	4
341	NUCLEAR MEDICINE 131 BILL TYPE	4	4
342	NUCLEAR MEDICINE 141 BILL TYPE	4	4
343	NUC MED/DX RADIOPHARM	4	0
344	NUC MED/RX RADIOPHARM	1	0
349	NUC MED/OTHER	4	4
350	CT SCAN - GENERAL	4	4
351	CT SCAN - HEAD	4	4
352	CT SCAN - BODY	4	4
359	CT SCAN/OTHER	4	4
360	OPERATING ROOM SERVICES - GENER	1	0
361	OR-MINOR	1	0
362	ORGAN TRANSPLANT-OTHER THAN K	2	0
367	O.R. SERVICES - KIDNEY TRANSPLAN	2	0
369	OR/OTHER	1	0
370	ANESTHESIA	1	0
371	ANESTHE-INCIDENT RAD	0	0
372	ANESTHESIA INCIDENT TO OTH DIAG	0	0
374	ANESTHE-ACUPUNC	0	0
379	ANESTHE-OTHER	0	0
380	BLOOD	1	2
381	PACKED RED CELLS	1	2
382	WHOLE BLOOD	1	2
383	PLASMA	1	2

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
384	PLATELETS	1	2
385	LEUCOCYTES	1	2
386	BLOOD-OTHER COMPONENTS	1	2
387	BLOOD-OTHER DERIVATIVES	1	2
389	OTHER BLOOD	1	0
390	BLOOD STORAGE AND PROCESSING	1	2
391	BLOOD-ADMIN	1	2
399	BLOOD-OTHER STORAGE	0	0
400	OTHER IMAGING SERVICES - GENERA	4	4
401	MAMMOGRAPHY	4	4
402	OTHER IMAGING SERVICES - ULTRAS	4	4
403	MAMMOGRAPHY SCREENING	4	4
404	PET SCAN	4	0
410	RESPIRATORY SERVICES	1	2
412	RESPIRATORY/INHALATION SERVICE	1	2
413	HYPERBARIC OXYGEN THERAPY	1	2
419	OTHER RESPERATORY	1	2
420	PHYSICAL THERAPY	1	2
421	PHYS THERP/VISIT	0	0
422	PHYS THERP/HOUR	0	0
423	PHYS THERP/GROUP	0	0
424	PHYSICAL THERAPY EVALUATION RE	1	2
429	OTHER PHYS THERP	0	0
430	OCCUPATIONAL THERAPY	1	2
431	OCCUP THERP/VISIT	0	0
432	OCCUP THERP/HOUR	0	0
433	OCCUP THERP/GROUP	0	0
434	OCCUPATIONAL THERAPY REEVALUA	1	2
439	RESTORATIVE THERAPY	0	0
440	SPEECH-LANGUAGE PATHOLOGY	1	2
441	SPEECH PATH/VISIT	0	0
442	SPEECH PATH/HOUR	0	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
443	SPEECH PATH/GROUP	0	0
444	SPEECH LANGUAGE EVALUATION	1	0
449	OTHER SPEECH PATH	0	0
450	EMERGENCY ROOM	1	2
451	ER/EMTALA	3	0
452	ER/BEYOND EMTALA	0	0
456	URGENT CARE	1	2
459	OTHER EMERGENCY ROOM	3	0
460	PULMONARY FUNCTION	1	4
469	OTHER PULMON FUNC	1	4
470	AUDIOLOGY	1	4
471	DIAGNOSTIC AUDIOLOGY	1	4
472	AUDIOLOGY/RX	1	4
479	OTHER AUDIOL	1	4
480	CARDIOLOGY - GENERAL	1	4
481	CARDIOLOGY - CARDIAC CATH LAB	1	4
482	CARDIAC STRESS TEST	1	0
483	ECHOCARDIOLOGY	1	4
489	OTHER CARDIOL	1	4
490	AMBULATORY SURGICAL CARE	3	0
499	OTHER AMBL SURG	3	0
500	OUTPATIENT SVS	3	0
509	OTHER OUTPATIENT SERVICES	3	0
510	CLINIC	3	2
511	CHRONIC PAIN CENTER	3	2
512	DENTAL CLINIC	3	2
513	PSYCHIATRIC CLINIC	3	2
514	OB-GYN CLINIC	3	2
515	PEDIATRIC CLINIC	3	2
516	URGENT CARE CLINIC	3	2
517	FAMILY PRACTICE CLINIC	3	2
519	OTHER CLINIC	3	2

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
520	FREESTAND CLINIC	3	2
521	RURAL CLINIC	3	2
522	RURAL HOME	3	2
523	FAMILY PRACTICE CLINIC-FREE STAN	3	2
526	URGENT CARE CLINIC-FREE STANDIN	3	2
529	OTHER FR/STD CLINIC	3	2
530	OSTEOPATHIC SERVICES	0	0
531	OSTEOPATH RX	0	0
539	OTHER OSTEOPATH	0	0
540	AMBULANCE	0	0
541	MED-SURG SUPPLIES USED IN AMBUL	0	0
542	TRANSPORT FOR NONEMERGENT CA	0	0
543	AMBULANCE HEARTMOBILE	0	0
544	OXYGEN USED DURING AMBULANCE	0	0
545	AIR AMBULANCE	0	0
546	NEONATAL AMBULANCE	0	0
547	AMBULANCE/PHARMACY	0	0
548	AMBULANCE/TELEPHONIC	0	0
549	OTHER AMBULANCE	0	0
550	SKILLED NURSING	0	0
551	SKILLED NURS/VISIT	0	0
552	SKILLED NURS/HOUR	0	0
559	SKILLED NURS/OTHER	0	0
560	MEDICAL SOCIAL SERVICES	0	0
561	MED SOC SERVS-VISIT	0	0
562	MED SOC SERV-HOUR	0	0
569	MED SOC SERV-OTHER	0	0
570	AIDE/HOME HEALTH	0	0
571	AIDE/HOME HEALTH/VISIT	0	0
572	AIDE/HOME HEALTH/HOUR	0	0
579	AIDE/HOME HEALTH/OTHER	0	0
580	VISIT-HOME HEALTH	0	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
581	VISIT-HOME HEALTH-VISIT	0	0
582	VISIT-HOME HEALTH-HOUR	0	0
589	VISIT-HOME HEALTH-OTHER	0	0
590	UNIT-HOME HEALTH	0	0
599	UNIT-HOME HEALTH-OTHER	0	0
600	OXYGEN - GENERAL	1	0
601	OXYGEN STATE/EQUIP/SUPPLIES	1	0
602	OXYGEN STATE/EQUIP/SUPPLIES < 1 L	1	0
603	OXYGEN STATE/EQUIP/SUPPLIES > 4 L	1	0
604	OXYGEN PORTABLE ADD-ON	1	0
610	MAGNETIC RESONANCE IMAGING	4	4
611	MAGNETIC RESONANCE IMAGING-BR	4	4
612	MAGNETIC RESONANCE IMAGING-SP	4	4
614	MRI – Other	4	4
615	MRA - HEAD & NECK	4	4
616	MRA-LOWER EXTREMITIES	4	4
618	MRA - OTHER	4	4
619	MAGNETIC RESONANCE IMAGING-OT	4	4
621	SUPPLIES INCIDENT TO RADIOLOGY	1	0
622	SUPPLIES INCIDENT TO OTH DIAG SER	1	0
623	SURGICAL DRESSINGS	1	0
624	FDA INVESTIGATION DEVICE	1	0
630	DRUGS	1	0
631	DRUG/SINGLE SRC	1	0
632	DRUG/MULTIPLE	1	0
633	DRUG/RESTRICTIVE	1	0
634	EPOADMINISTERED< 10000 UNITS	4	4
635	EPO ADMINISTERED > PER 1000 UNIT	4	4
636	DRUGS REQUIRING SPECIFIC IDENT	4	0
637	SELF ADMISTERING DRUGS	1	2
640	IV THERAPY SERVICES	0	0
641	NON RT NURSING-CENTRAL	0	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
642	IV SITE CARE-CENTRAL	0	0
643	IV STRT-CHNG-PERIPHAL	0	0
644	NONRT NURSING-PERIPHAL	0	0
645	TRNG PT-CAREGVR-CENTRAL	0	0
646	TRNG DSBLPT-CENTRAL	0	0
647	TRNG-PT-CAREGVR-PERIPHRL	0	0
648	TRNG-DSBLPAT-PERIPHAL	0	0
649	OTHER IV THERAPY SVC	0	0
650	HOSPICE	0	0
651	HOSPICE-RTN HOME	0	0
652	HOSPICE-CTNS HOME	0	0
655	HOSPICE IP RESPITE	0	0
656	HOSPICE-IP NON-RESPITE	0	0
657	HOSPICE-PHYSICIAN	0	0
659	HOSPICE-OTHER	0	0
660	RESPITE CARE	0	0
661	RESPITE-SKILLED NURSE	0	0
662	RESPITE-HMAID-HMEMBER	0	0
670	OP SPEC RES	0	0
671	OP SPEC RES/HOSPITAL BASED	0	0
672	OP SPEC RES/CONTRACTED	0	0
681	TRAUMA LEVEL I	0	0
682	TRAUMA LEVEL II	0	0
683	TRAUMA LEVEL III	0	0
684	TRAUMA LEVEL IV	0	0
700	CASTROOM	1	0
709	OTHER CAST ROOM	1	0
710	RECOVERY ROOM	1	0
719	OTHER RECOV RM	1	0
720	LABOR ROOM/DELIVERY	1	0
721	LABOR ROOM	1	0
722	DELIVERY ROOM	1	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
723	CIRCUMCISION	1	0
724	BIRTHING CENTER	1	0
729	OTHER DELIVERY	1	0
730	EKG/ECG	1	4
731	24 HOUR HOLTER MONITOR	1	4
732	TELEMTRY	1	4
739	OTHER EKG-ECG	1	4
740	EEG	1	4
749	OTHER EEG	1	4
750	GASTRO-INTESTINAL SERVICES	1	4
759	OTHER GASTRO-INTS	1	4
760	GENERAL TREATMENT OR OBSERVAT	0	0
761	TREATMENT ROOM	3	2
762	OBSERVATION ROOM	1	0
769	INTENSIVE OBSERVATION	1	0
770	PREVENT CARE SVS	0	0
771	VACCINE ADMIN	0	0
779	OTHER PREVENT	0	0
780	TELEMEDICINE, GENERAL	1	0
789	TELEMEDICINE, OTHER	1	0
790	LITHOTRIPSY	1	0
799	LITHOTRIPSY-OTHER	1	4
800	INPATIENT RENAL DIALYSIS - GENER	2	2
801	INPATIENT HEMODIALYSIS	2	2
802	INPATIENT PERITONEAL (NON-CAPD)	2	2
803	I.P. CONT. AMB PERITONEAL DIAL (CA	2	2
804	I.P. CONT CYCLING PERITONEAL DIAL	2	2
809	OTHER INPATIENT DIALYSIS	2	2
810	KIDNEY ACQUISITION GENERAL	2	0
811	KIDNEY ACQUISITION - LIVING DONO	1	0
812	KIDNEY ACQUISITION - CADAVER DO	1	0
813	KIDNEY ACQUISITION - UNKNOWN DO	1	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
814	OTHER KIDNEY ACQUISITION	2	0
815	CADAVER DONOR HEART	0	0
816	OTHER HEART ACQUISITION	0	0
817	LIVER DONOR	0	0
819	KIDNEY ACQUISITION - OTHER KIDNE	1	0
820	HEMODIALYSIS OP/HOME - GENERAL	3	2
821	HEMO OP/HOME - HEMO/COMPOS OR	3	2
822	HEMO OP/HOME - HOME SUPPLIES	0	0
823	HEMO OP/HOME - HOME EQUIPMENT	0	0
824	HEMO OP/HOME - MAINTENANCE 100	0	0
825	HEMO OP/HOME SUPPORT SERVICES	0	0
829	HEMO OP/HOME - OTHER OP HEMO	0	0
830	PERITONEAL DIAL - OP/HOME - GENE	3	2
831	PERI DIAL-OP/HOME -PERILCOMP OR	3	2
832	PERI DIAL OP/HOME - HOME SUPPLIE	0	0
833	PERI DIAL OP/HOME - HOME EQUIPME	0	0
834	PERI DIAL OP/HOME / MAINTENANCE	0	0
835	PERI DIAL OP/HOME - SUPPORT SERV	0	0
839	PERI DIAL OP/HOME - OTHER OP PERI	0	0
840	CONT AMB PERI (CAPD) - OP/HOME - G	3	2
841	CONT AMB PERI CAPD-OP/HOME-CAP	3	2
842	CONT AMB PERI (CAPD) OP/HOME -HO	0	0
843	CONT AMB PERI (CAPD) OP/HOME-HO	0	0
844	CONT AMB PERI (CAPD) OP/HOME-MA	0	0
845	CONT AMB PERI (CAPD) OP/HOME SU	0	0
849	CONT AMB PERI (CAPD) OP/HOME OT	0	0
850	CONT CYC PERI (CCPD) OP/HOME - GE	3	2
851	CONT CYC PERI (CCPD) OP/HOME CC	3	2
852	CONT CYC PERI (CCPD) OP/HOME - HO	0	0
853	CONT CYC PERI (CCPD) OP/HOME - EQ	0	0
854	CONT CYC PERI (CCPD) OP/HOME -MA	0	0
855	CONT CYC PERI (CCPD) OP/HOME - SU	0	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
859	CONT CYC PERI CCPD OP/HOME OTH	0	0
860	RESERVED FOR NATNL ASSIGNMENT	0	0
870	RESERVED FOR NATNL ASSIGNMENT	0	0
880	MISCELLANEOUS DIALYSIS - GENERA	0	0
881	MISCELLANEOUS DIALYSIS - ULTRAF	0	0
882	HOME DIALYSIS AID VISIT	0	0
889	MISCELLANEOUS DIALYSIS - OTHER	0	0
890	OTHER DONOR BANK	0	0
900	PSYCHIC/PSYCHO TX - GENERAL	1	2
901	PSYCHIC/PSYCHO TX ELECTROSHOCK	1	2
902	PSYCHIC/PSYCHO TX - MILIEU THERA	0	0
903	PSYCHIC/PSYCHO TX - PLAY THERAP	0	0
904	ACTIVITY THERAPY	0	0
909	PSYCHIC/PSYCHO TX - OTHER	0	0
910	PSYCHIC/PSYCHO SERV - GENERAL	1	2
911	PSYCHIC/PSYCHO SERV - REHABILITA	0	0
912	PSYCH / PARTIAL HOSP.	0	0
913	PSYCHIC/PSYCHO SERVICES-NIGT CA	0	0
914	PSYCHIC/PSYCHO SERV - INDIVIDUAL	1	2
915	PSYCHIC/PSYCHO SERV -GROUP THE	1	2
916	PSYCHIC/PSYCHO SERV - FAMILY THE	1	2
917	PSYCHIC/PSYCHO SERV - BIO FEEDBA	0	0
918	PSYCHIC/PSYCHO SERV - TESTING	1	2
919	PSYCHIC/PSYCHO SERV - OTHER	0	0
920	OTHER DIAGNOSTIC SERVICES - GENE	1	2
921	OTHER DIAG SERV -PERIPHERAL VAS	1	2
922	OTHER DIAG SERV - ELECTROMYELG	1	2
923	PAP SMEAR	4	4
924	ALLERGY TEST	1	4
925	PREGNANCY TEST	0	2
929	OTHER DIAGNOSTIC SERVICES	1	2
940	OTHER THERAPEUTIC - GENERAL	1	2

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
941	OTHER THERAPEUTIC SERV REC THE	0	0
942	OTHER THERAPEUTIC SERV - EDUC/T	0	0
943	OTHER THERAPEUTIC SERV - CARDIA	1	2
944	OTHER THERAPEUTIC SERV - DRUG R	0	0
945	OTHER THERAPEUTIC SERV - ALCOHO	0	0
946	COMPLEX MEDICAL EQUIP. ROUTINE	1	0
947	COMPLEX MEDICAL EQUIP. ANCILLAR	1	0
949	OTHER THERAPEUTIC SERVICES - OT	0	0
960	PROFESSIONAL FEES	0	0
961	PRO FEE/PSYCH	0	0
962	PRO FEE/EYE	0	0
963	PRO FEE/ANES MD	0	0
964	CRNA	0	0
969	OTHER PRO FEES	0	0
971	PROFESSIONAL FEE / LAB	0	0
972	PRO FEES RADIOLOGY DIAGNOSTI	0	0
973	PRO FEES RADIOLOGY THERAPEU	0	0
974	PRO FEES RADIOLOGY NUCLEAR M	0	0
975	PRO FEE-OR	0	0
976	PRO FEE-RESPIR	0	0
977	PRO FEE-PHYSI	0	0
978	PRO FEE-OCUPA	0	0
979	PRO FEE-SPEECH	0	0
981	ER PROFESSIONAL FEES	0	0
982	PRO FEES OUTPATIENT SERVICES	0	0
983	PRO FEES CLINIC	0	0
984	PRO FEE-SOC SVC	0	0
985	PRO FEES EKG	0	0
986	PRO FEES EEG	0	0
987	PRO FEES HOSPITAL VISIT	0	0
988	PROFESSIONAL FEES CONSULTATION	0	0
989	FEE-PVT NURSE	0	0

SECTION 4 BILLING CODES

REVENUE CODES

Revenue Code	Description	Covered Service	Units/ Room
990	PATIENT CONVENIENCE ITEMS	0	0
991	CAFETERIA	0	0
992	LINEN	0	0
993	TELEPHONE	0	0
994	TV/RADIO	0	0
995	NONPT ROOM RENT	0	0
996	LATE DISCHARGE	0	0
997	ADMIT KITS	0	0
998	BARBER/BEAUTY	0	0
999	PT CONVENENCE/OTHER	0	0

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

Effective: October 1, 2015

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
001-1	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	7.63	$98,000	No	7.4839	Miscellaneous	Gastroent
001-2	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	8.57	$98,000	No	7.5257	Miscellaneous	Gastroent
001-3	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	12.52	$98,000	No	8.8396	Miscellaneous	Gastroent
001-4	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	31.57	$98,000	No	15.3728	Miscellaneous	Gastroent
002-1	HEART &/OR LUNG TRANSPLANT	9.37	$98,000	No	8.1602	Miscellaneous	Miscellaneous
002-2	HEART &/OR LUNG TRANSPLANT	14.70	$98,000	No	9.6671	Miscellaneous	Miscellaneous
002-3	HEART &/OR LUNG TRANSPLANT	21.53	$98,000	No	12.0550	Miscellaneous	Miscellaneous
002-4	HEART &/OR LUNG TRANSPLANT	36.72	$98,000	No	18.0801	Miscellaneous	Miscellaneous
003-1	BONE MARROW TRANSPLANT	16.93	$70,038	No	4.2402	Miscellaneous	Miscellaneous
003-2	BONE MARROW TRANSPLANT	22.57	$98,000	No	6.2664	Miscellaneous	Miscellaneous
003-3	BONE MARROW TRANSPLANT	32.80	$98,000	No	10.1363	Miscellaneous	Miscellaneous
003-4	BONE MARROW TRANSPLANT	51.19	$98,000	No	18.2162	Miscellaneous	Miscellaneous
004-1	ECMO OR TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE	22.90	$98,000	No	6.4916	Miscellaneous	Miscellaneous
004-2	ECMO OR TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE	20.60	$98,000	No	6.7502	Miscellaneous	Miscellaneous
004-3	ECMO OR TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE	26.40	$98,000	No	9.2479	Miscellaneous	Miscellaneous
004-4	ECMO OR TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE	38.59	$98,000	No	14.1600	Miscellaneous	Miscellaneous
005-1	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE	27.74	$98,000	No	4.9003	Miscellaneous	Miscellaneous
005-2	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE	19.47	$98,000	No	5.2326	Miscellaneous	Miscellaneous
005-3	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE	23.94	$98,000	No	6.7135	Miscellaneous	Miscellaneous
005-4	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE	32.79	$98,000	No	9.5917	Miscellaneous	Miscellaneous
006-1	PANCREAS TRANSPLANT	5.90	$98,000	No	7.5340	Miscellaneous	Gastroent

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
006-2	PANCREAS TRANSPLANT	8.13	$98,000	No	8.4835	Miscellaneous	Gastroent
006-3	PANCREAS TRANSPLANT	10.16	$98,000	No	9.0983	Miscellaneous	Gastroent
006-4	PANCREAS TRANSPLANT	24.71	$98,000	No	13.9742	Miscellaneous	Gastroent
020-1	CRANIOTOMY FOR TRAUMA	5.41	$42,560	No	1.7474	Miscellaneous	Miscellaneous
020-2	CRANIOTOMY FOR TRAUMA	6.37	$59,388	No	2.2987	Miscellaneous	Miscellaneous
020-3	CRANIOTOMY FOR TRAUMA	9.94	$95,576	No	3.2365	Miscellaneous	Miscellaneous
020-4	CRANIOTOMY FOR TRAUMA	16.89	$98,000	No	5.7909	Miscellaneous	Miscellaneous
021-1	CRANIOTOMY EXCEPT FOR TRAUMA	3.99	$45,136	No	1.9469	Miscellaneous	Miscellaneous
021-2	CRANIOTOMY EXCEPT FOR TRAUMA	5.80	$53,941	No	2.5682	Miscellaneous	Miscellaneous
021-3	CRANIOTOMY EXCEPT FOR TRAUMA	10.38	$61,884	No	3.7498	Miscellaneous	Miscellaneous
021-4	CRANIOTOMY EXCEPT FOR TRAUMA	18.50	$98,000	No	6.2980	Miscellaneous	Miscellaneous
022-1	VENTRICULAR SHUNT PROCEDURES	2.81	$33,000	No	1.1880	Miscellaneous	Miscellaneous
022-2	VENTRICULAR SHUNT PROCEDURES	5.36	$33,000	No	1.5662	Miscellaneous	Miscellaneous
022-3	VENTRICULAR SHUNT PROCEDURES	11.09	$98,000	No	2.8925	Miscellaneous	Miscellaneous
022-4	VENTRICULAR SHUNT PROCEDURES	18.29	$98,000	No	5.1610	Miscellaneous	Miscellaneous
023-1	SPINAL PROCEDURES	3.30	$33,000	No	1.3295	Miscellaneous	Miscellaneous
023-2	SPINAL PROCEDURES	5.76	$33,457	No	1.8228	Miscellaneous	Miscellaneous
023-3	SPINAL PROCEDURES	10.33	$98,000	No	3.7131	Miscellaneous	Miscellaneous
023-4	SPINAL PROCEDURES	20.28	$98,000	No	6.4257	Miscellaneous	Miscellaneous
024-1	EXTRACRANIAL VASCULAR PROCEDURES	1.55	$38,570	No	1.0743	Miscellaneous	Miscellaneous
024-2	EXTRACRANIAL VASCULAR PROCEDURES	2.91	$50,072	No	1.4223	Miscellaneous	Miscellaneous
024-3	EXTRACRANIAL VASCULAR PROCEDURES	7.49	$98,000	No	2.7477	Miscellaneous	Miscellaneous
024-4	EXTRACRANIAL VASCULAR PROCEDURES	13.61	$98,000	No	5.2766	Miscellaneous	Miscellaneous
026-1	OTHER NERVOUS SYSTEM & RELATED PROCEDURES	2.61	$33,000	No	1.1695	Miscellaneous	Miscellaneous
026-2	OTHER NERVOUS SYSTEM & RELATED PROCEDURES	4.45	$54,250	No	1.5931	Miscellaneous	Miscellaneous
026-3	OTHER NERVOUS SYSTEM & RELATED PROCEDURES	9.13	$74,692	No	2.4162	Miscellaneous	Miscellaneous
026-4	OTHER NERVOUS SYSTEM & RELATED PROCEDURES	21.04	$98,000	No	4.8720	Miscellaneous	Miscellaneous
040-1	SPINAL DISORDERS & INJURIES	3.62	$33,000	No	0.7950	Miscellaneous	Miscellaneous
040-2	SPINAL DISORDERS & INJURIES	4.97	$33,000	No	0.9647	Miscellaneous	Miscellaneous
040-3	SPINAL DISORDERS & INJURIES	7.97	$35,999	No	1.3170	Miscellaneous	Miscellaneous
040-4	SPINAL DISORDERS & INJURIES	16.13	$80,230	No	2.6793	Miscellaneous	Miscellaneous
041-1	NERVOUS SYSTEM MALIGNANCY	3.07	$33,000	No	0.6835	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
041-2	NERVOUS SYSTEM MALIGNANCY	3.89	$33,000	No	0.7312	Miscellaneous	Miscellaneous
041-3	NERVOUS SYSTEM MALIGNANCY	6.14	$33,000	No	1.0508	Miscellaneous	Miscellaneous
041-4	NERVOUS SYSTEM MALIGNANCY	9.93	$79,710	No	1.7616	Miscellaneous	Miscellaneous
042-1	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS	5.21	$33,000	No	0.5230	Miscellaneous	Miscellaneous
042-2	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS	8.86	$33,000	No	0.7626	Miscellaneous	Miscellaneous
042-3	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS	9.18	$51,919	No	1.0113	Miscellaneous	Miscellaneous
042-4	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS	13.30	$77,617	No	2.1932	Miscellaneous	Miscellaneous
043-1	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	3.57	$33,000	No	0.6705	Miscellaneous	Miscellaneous
043-2	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	4.79	$33,000	No	0.8542	Miscellaneous	Miscellaneous
043-3	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	8.27	$35,914	No	1.3082	Miscellaneous	Miscellaneous
043-4	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	16.51	$93,277	No	2.8853	Miscellaneous	Miscellaneous
044-1	INTRACRANIAL HEMORRHAGE	3.50	$33,000	No	0.6526	Miscellaneous	Miscellaneous
044-2	INTRACRANIAL HEMORRHAGE	4.62	$34,939	No	0.8877	Miscellaneous	Miscellaneous
044-3	INTRACRANIAL HEMORRHAGE	5.47	$48,544	No	1.1157	Miscellaneous	Miscellaneous
044-4	INTRACRANIAL HEMORRHAGE	8.98	$82,600	No	2.0771	Miscellaneous	Miscellaneous
045-1	CVA & PRECEREBRAL OCCLUSION W INFARCT	2.79	$33,000	No	0.7518	Miscellaneous	Miscellaneous
045-2	CVA & PRECEREBRAL OCCLUSION W INFARCT	3.92	$33,000	No	0.9090	Miscellaneous	Miscellaneous
045-3	CVA & PRECEREBRAL OCCLUSION W INFARCT	6.17	$37,978	No	1.2516	Miscellaneous	Miscellaneous
045-4	CVA & PRECEREBRAL OCCLUSION W INFARCT	11.02	$98,000	No	2.3311	Miscellaneous	Miscellaneous
046-1	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	2.62	$33,000	No	0.6594	Miscellaneous	Miscellaneous
046-2	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	3.27	$33,000	No	0.8050	Miscellaneous	Miscellaneous
046-3	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	5.02	$33,000	No	1.0523	Miscellaneous	Miscellaneous
046-4	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	9.50	$56,439	No	1.8762	Miscellaneous	Miscellaneous
047-1	TRANSIENT ISCHEMIA	1.93	$33,000	No	0.5943	Miscellaneous	Miscellaneous
047-2	TRANSIENT ISCHEMIA	2.52	$33,000	No	0.6664	Miscellaneous	Miscellaneous
047-3	TRANSIENT ISCHEMIA	3.83	$33,000	No	0.8503	Miscellaneous	Miscellaneous
047-4	TRANSIENT ISCHEMIA	8.77	$46,963	No	1.7352	Miscellaneous	Miscellaneous
048-1	PERIPHERAL, CRANIAL & AUTONOMIC	2.76	$33,000	No	0.5447	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
	NERVE DISORDERS						
048-2	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	3.81	$33,000	No	0.6543	Miscellaneous	Miscellaneous
048-3	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	5.38	$33,000	No	0.8920	Miscellaneous	Miscellaneous
048-4	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	12.92	$62,458	No	2.1686	Miscellaneous	Miscellaneous
049-1	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	5.43	$33,000	No	0.8284	Miscellaneous	Miscellaneous
049-2	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	6.70	$43,222	No	1.6420	Miscellaneous	Miscellaneous
049-3	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	10.61	$75,997	No	2.0963	Miscellaneous	Miscellaneous
049-4	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	16.01	$98,000	No	3.6169	Miscellaneous	Miscellaneous
050-1	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS	3.92	$33,000	No	0.5934	Miscellaneous	Miscellaneous
050-2	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS	5.58	$33,000	No	0.9905	Miscellaneous	Miscellaneous
050-3	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS	8.82	$34,471	No	1.6195	Miscellaneous	Miscellaneous
050-4	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS	15.59	$98,000	No	3.7266	Miscellaneous	Miscellaneous
051-1	VIRAL MENINGITIS	2.63	$33,000	No	0.4819	Miscellaneous	Miscellaneous
051-2	VIRAL MENINGITIS	3.77	$33,000	No	0.7310	Miscellaneous	Miscellaneous
051-3	VIRAL MENINGITIS	6.47	$33,000	No	1.2961	Miscellaneous	Miscellaneous
051-4	VIRAL MENINGITIS	12.70	$76,519	No	3.0542	Miscellaneous	Miscellaneous
052-1	NONTRAUMATIC STUPOR & COMA	2.13	$33,000	No	0.5281	Miscellaneous	Miscellaneous
052-2	NONTRAUMATIC STUPOR & COMA	3.22	$33,000	No	0.6260	Miscellaneous	Miscellaneous
052-3	NONTRAUMATIC STUPOR & COMA	5.18	$33,000	No	0.8795	Miscellaneous	Miscellaneous
052-4	NONTRAUMATIC STUPOR & COMA	10.99	$73,331	No	2.0139	Miscellaneous	Miscellaneous
053-1	SEIZURE	2.31	$33,000	No	0.4455	Miscellaneous	Miscellaneous
053-2	SEIZURE	2.92	$33,000	No	0.5716	Miscellaneous	Miscellaneous
053-3	SEIZURE	4.41	$33,000	No	0.8166	Miscellaneous	Miscellaneous
053-4	SEIZURE	9.78	$64,469	No	2.0593	Miscellaneous	Miscellaneous
054-1	MIGRAINE & OTHER HEADACHES	2.37	$33,000	No	0.4789	Miscellaneous	Miscellaneous
054-2	MIGRAINE & OTHER HEADACHES	2.82	$33,000	No	0.5953	Miscellaneous	Miscellaneous
054-3	MIGRAINE & OTHER HEADACHES	3.92	$33,000	No	0.7614	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
054-4	MIGRAINE & OTHER HEADACHES	6.87	$42,173	No	1.2141	Miscellaneous	Miscellaneous
055-1	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	2.27	$33,000	No	0.5689	Miscellaneous	Miscellaneous
055-2	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	3.57	$33,000	No	0.7922	Miscellaneous	Miscellaneous
055-3	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	5.37	$33,000	No	1.2059	Miscellaneous	Miscellaneous
055-4	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	10.42	$98,000	No	2.3924	Miscellaneous	Miscellaneous
056-1	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA	2.27	$33,000	No	0.5776	Miscellaneous	Miscellaneous
056-2	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA	3.68	$33,000	No	0.8299	Miscellaneous	Miscellaneous
056-3	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA	5.99	$47,589	No	1.3057	Miscellaneous	Miscellaneous
056-4	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA	13.35	$84,559	No	3.1575	Miscellaneous	Miscellaneous
057-1	CONCUSSION, CLOSED SKULL FX NOS,UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	1.52	$33,000	No	0.5206	Miscellaneous	Miscellaneous
057-2	CONCUSSION, CLOSED SKULL FX NOS,UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	2.43	$33,000	No	0.7483	Miscellaneous	Miscellaneous
057-3	CONCUSSION, CLOSED SKULL FX NOS,UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	4.41	$33,000	No	1.1393	Miscellaneous	Miscellaneous
057-4	CONCUSSION, CLOSED SKULL FX NOS,UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	10.35	$72,330	No	2.5044	Miscellaneous	Miscellaneous
058-1	OTHER DISORDERS OF NERVOUS SYSTEM	2.78	$33,000	No	0.5742	Miscellaneous	Miscellaneous
058-2	OTHER DISORDERS OF NERVOUS SYSTEM	4.09	$33,000	No	0.7054	Miscellaneous	Miscellaneous
058-3	OTHER DISORDERS OF NERVOUS SYSTEM	6.16	$33,000	No	0.9583	Miscellaneous	Miscellaneous
058-4	OTHER DISORDERS OF NERVOUS SYSTEM	12.35	$61,498	No	1.9421	Miscellaneous	Miscellaneous
070-1	ORBITAL PROCEDURES	2.13	$33,000	No	0.7704	Miscellaneous	Miscellaneous
070-2	ORBITAL PROCEDURES	3.76	$33,000	No	1.1459	Miscellaneous	Miscellaneous
070-3	ORBITAL PROCEDURES	6.77	$55,003	No	2.0583	Miscellaneous	Miscellaneous
070-4	ORBITAL PROCEDURES	13.19	$98,000	No	4.1149	Miscellaneous	Miscellaneous
073-1	EYE PROCEDURES EXCEPT ORBIT	2.27	$33,000	No	0.7118	Miscellaneous	Miscellaneous
073-2	EYE PROCEDURES EXCEPT ORBIT	3.13	$33,000	No	0.8959	Miscellaneous	Miscellaneous
073-3	EYE PROCEDURES EXCEPT ORBIT	5.45	$34,253	No	1.3025	Miscellaneous	Miscellaneous
073-4	EYE PROCEDURES EXCEPT ORBIT	18.55	$84,143	No	3.0347	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
080-1	ACUTE MAJOR EYE INFECTIONS	2.94	$33,000	No	0.3772	Miscellaneous	Miscellaneous
080-2	ACUTE MAJOR EYE INFECTIONS	3.94	$33,000	No	0.5292	Miscellaneous	Miscellaneous
080-3	ACUTE MAJOR EYE INFECTIONS	6.24	$33,000	No	0.8869	Miscellaneous	Miscellaneous
080-4	ACUTE MAJOR EYE INFECTIONS	12.04	$60,163	No	2.2853	Miscellaneous	Miscellaneous
082-1	EYE DISORDERS EXCEPT MAJOR INFECTIONS	2.30	$33,000	No	0.4191	Miscellaneous	Miscellaneous
082-2	EYE DISORDERS EXCEPT MAJOR INFECTIONS	2.81	$33,000	No	0.5782	Miscellaneous	Miscellaneous
082-3	EYE DISORDERS EXCEPT MAJOR INFECTIONS	4.32	$34,392	No	0.8004	Miscellaneous	Miscellaneous
082-4	EYE DISORDERS EXCEPT MAJOR INFECTIONS	15.89	$73,209	No	1.8093	Miscellaneous	Miscellaneous
089-1	MAJOR CRANIAL/FACIAL BONE PROCEDURES	2.31	$45,329	No	1.4058	Miscellaneous	Miscellaneous
089-2	MAJOR CRANIAL/FACIAL BONE PROCEDURES	3.85	$58,203	No	1.8500	Miscellaneous	Miscellaneous
089-3	MAJOR CRANIAL/FACIAL BONE PROCEDURES	8.77	$98,000	No	3.2437	Miscellaneous	Miscellaneous
089-4	MAJOR CRANIAL/FACIAL BONE PROCEDURES	16.34	$98,000	No	5.7616	Miscellaneous	Miscellaneous
090-1	MAJOR LARYNX & TRACHEA PROCEDURES	2.60	$33,000	No	0.7158	Miscellaneous	Miscellaneous
090-2	MAJOR LARYNX & TRACHEA PROCEDURES	8.09	$54,466	No	2.2218	Miscellaneous	Miscellaneous
090-3	MAJOR LARYNX & TRACHEA PROCEDURES	13.56	$82,761	No	3.5815	Miscellaneous	Miscellaneous
090-4	MAJOR LARYNX & TRACHEA PROCEDURES	25.02	$98,000	No	7.1443	Miscellaneous	Miscellaneous
091-1	OTHER MAJOR HEAD & NECK PROCEDURES	3.24	$33,000	No	1.3026	Miscellaneous	Miscellaneous
091-2	OTHER MAJOR HEAD & NECK PROCEDURES	4.64	$80,206	No	1.8978	Miscellaneous	Miscellaneous
091-3	OTHER MAJOR HEAD & NECK PROCEDURES	9.60	$98,000	No	3.5965	Miscellaneous	Miscellaneous
091-4	OTHER MAJOR HEAD & NECK PROCEDURES	19.19	$98,000	No	6.3239	Miscellaneous	Miscellaneous
092-1	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES	2.01	$33,000	No	0.9831	Miscellaneous	Miscellaneous
092-2	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES	2.93	$49,907	No	1.3810	Miscellaneous	Miscellaneous
092-3	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES	6.06	$60,961	No	2.2378	Miscellaneous	Miscellaneous
092-4	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES	14.11	$98,000	No	4.9305	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
093-1	SINUS & MASTOID PROCEDURES	2.36	$33,000	No	0.9483	Miscellaneous	Miscellaneous
093-2	SINUS & MASTOID PROCEDURES	3.89	$33,000	No	1.2524	Miscellaneous	Miscellaneous
093-3	SINUS & MASTOID PROCEDURES	7.25	$50,478	No	1.9561	Miscellaneous	Miscellaneous
093-4	SINUS & MASTOID PROCEDURES	12.68	$81,406	No	3.0863	Miscellaneous	Miscellaneous
095-1	CLEFT LIP & PALATE REPAIR	1.43	$33,000	No	0.6260	Miscellaneous	Miscellaneous
095-2	CLEFT LIP & PALATE REPAIR	2.07	$33,000	No	0.7686	Miscellaneous	Miscellaneous
095-3	CLEFT LIP & PALATE REPAIR	4.04	$33,000	No	1.1912	Miscellaneous	Miscellaneous
095-4	CLEFT LIP & PALATE REPAIR	10.96	$98,000	No	2.1518	Miscellaneous	Miscellaneous
097-1	TONSIL & ADENOID PROCEDURES	1.56	$33,000	No	0.4084	Miscellaneous	Miscellaneous
097-2	TONSIL & ADENOID PROCEDURES	2.75	$33,000	No	0.6213	Miscellaneous	Miscellaneous
097-3	TONSIL & ADENOID PROCEDURES	5.72	$34,342	No	1.2162	Miscellaneous	Miscellaneous
097-4	TONSIL & ADENOID PROCEDURES	15.20	$93,523	No	3.2627	Miscellaneous	Miscellaneous
098-1	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES	2.11	$33,000	No	0.7047	Miscellaneous	Miscellaneous
098-2	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES	3.27	$33,000	No	0.9495	Miscellaneous	Miscellaneous
098-3	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES	6.80	$64,107	No	1.5476	Miscellaneous	Miscellaneous
098-4	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES	14.61	$92,329	No	3.2522	Miscellaneous	Miscellaneous
110-1	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	2.92	$33,000	No	0.4895	Miscellaneous	Miscellaneous
110-2	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	4.29	$33,000	No	0.7037	Miscellaneous	Miscellaneous
110-3	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	6.94	$36,171	No	1.1056	Miscellaneous	Miscellaneous
110-4	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	12.74	$73,685	No	2.2409	Miscellaneous	Miscellaneous
111-1	VERTIGO & OTHER LABYRINTH DISORDERS	2.01	$33,000	No	0.4864	Miscellaneous	Miscellaneous
111-2	VERTIGO & OTHER LABYRINTH DISORDERS	2.52	$33,000	No	0.5693	Miscellaneous	Miscellaneous
111-3	VERTIGO & OTHER LABYRINTH DISORDERS	3.50	$33,000	No	0.7226	Miscellaneous	Miscellaneous
111-4	VERTIGO & OTHER LABYRINTH DISORDERS	7.48	$33,000	No	1.3868	Miscellaneous	Miscellaneous
113-1	INFECTIONS OF UPPER RESPIRATORY TRACT	1.88	$33,000	No	0.2599	Respiratory	Respiratory
113-2	INFECTIONS OF UPPER RESPIRATORY TRACT	2.52	$33,000	No	0.4024	Respiratory	Respiratory
113-3	INFECTIONS OF UPPER RESPIRATORY TRACT	3.96	$33,000	No	0.6701	Respiratory	Respiratory
113-4	INFECTIONS OF UPPER RESPIRATORY TRACT	7.33	$33,000	No	1.3455	Respiratory	Respiratory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
114-1	DENTAL & ORAL DISEASES & INJURIES	2.21	$33,000	No	0.3711	Miscellaneous	Miscellaneous
114-2	DENTAL & ORAL DISEASES & INJURIES	2.97	$33,000	No	0.5697	Miscellaneous	Miscellaneous
114-3	DENTAL & ORAL DISEASES & INJURIES	5.46	$33,000	No	0.9274	Miscellaneous	Miscellaneous
114-4	DENTAL & ORAL DISEASES & INJURIES	10.61	$54,408	No	1.9812	Miscellaneous	Miscellaneous
115-1	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES	2.30	$33,000	No	0.4062	Miscellaneous	Miscellaneous
115-2	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES	2.99	$33,000	No	0.5955	Miscellaneous	Miscellaneous
115-3	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES	4.83	$33,000	No	0.8754	Miscellaneous	Miscellaneous
115-4	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES	9.64	$50,290	No	1.8371	Miscellaneous	Miscellaneous
120-1	MAJOR RESPIRATORY & CHEST PROCEDURES	4.87	$45,575	No	1.7189	Respiratory	Respiratory
120-2	MAJOR RESPIRATORY & CHEST PROCEDURES	6.78	$60,941	No	2.1945	Respiratory	Respiratory
120-3	MAJOR RESPIRATORY & CHEST PROCEDURES	11.38	$91,934	No	3.1960	Respiratory	Respiratory
120-4	MAJOR RESPIRATORY & CHEST PROCEDURES	19.39	$98,000	No	5.7404	Respiratory	Respiratory
121-1	OTHER RESPIRATORY & CHEST PROCEDURES	3.49	$33,000	No	1.1883	Respiratory	Respiratory
121-2	OTHER RESPIRATORY & CHEST PROCEDURES	5.48	$35,348	No	1.5313	Respiratory	Respiratory
121-3	OTHER RESPIRATORY & CHEST PROCEDURES	10.28	$45,091	No	2.4687	Respiratory	Respiratory
121-4	OTHER RESPIRATORY & CHEST PROCEDURES	19.37	$98,000	No	5.0342	Respiratory	Respiratory
130-1	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	14.54	$96,136	No	2.8511	Respiratory	Respiratory
130-2	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	12.63	$58,092	No	3.0423	Respiratory	Respiratory
130-3	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	14.49	$98,000	No	3.6434	Respiratory	Respiratory
130-4	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	19.67	$98,000	No	4.8144	Respiratory	Respiratory
131-1	CYSTIC FIBROSIS - PULMONARY DISEASE	6.96	$33,000	No	1.1407	Respiratory	Respiratory
131-2	CYSTIC FIBROSIS - PULMONARY DISEASE	8.20	$42,370	No	1.4020	Respiratory	Respiratory
131-3	CYSTIC FIBROSIS - PULMONARY DISEASE	10.28	$58,196	No	1.8525	Respiratory	Respiratory
131-4	CYSTIC FIBROSIS - PULMONARY DISEASE	13.22	$63,225	No	2.5460	Respiratory	Respiratory
132-1	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	3.45	$33,000	No	0.4233	Respiratory	Respiratory
132-2	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	4.42	$33,000	No	0.5181	Respiratory	Respiratory
132-3	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	7.10	$35,897	No	0.8051	Respiratory	Respiratory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
132-4	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	10.49	$33,000	No	1.4927	Respiratory	Respiratory
133-1	PULMONARY EDEMA & RESPIRATORY FAILURE	2.56	$33,000	No	0.5454	Respiratory	Respiratory
133-2	PULMONARY EDEMA & RESPIRATORY FAILURE	4.09	$33,000	No	0.7561	Respiratory	Respiratory
133-3	PULMONARY EDEMA & RESPIRATORY FAILURE	5.82	$36,225	No	1.0996	Respiratory	Respiratory
133-4	PULMONARY EDEMA & RESPIRATORY FAILURE	7.54	$55,692	No	1.7495	Respiratory	Respiratory
134-1	PULMONARY EMBOLISM	3.66	$33,000	No	0.7118	Respiratory	Respiratory
134-2	PULMONARY EMBOLISM	4.54	$33,000	No	0.9026	Respiratory	Respiratory
134-3	PULMONARY EMBOLISM	6.34	$33,000	No	1.2877	Respiratory	Respiratory
134-4	PULMONARY EMBOLISM	8.66	$55,546	No	1.9730	Respiratory	Respiratory
135-1	MAJOR CHEST & RESPIRATORY TRAUMA	2.83	$33,000	No	0.6398	Respiratory	Respiratory
135-2	MAJOR CHEST & RESPIRATORY TRAUMA	3.66	$33,000	No	0.8152	Respiratory	Respiratory
135-3	MAJOR CHEST & RESPIRATORY TRAUMA	5.76	$33,000	No	1.1912	Respiratory	Respiratory
135-4	MAJOR CHEST & RESPIRATORY TRAUMA	8.34	$35,655	No	2.1261	Respiratory	Respiratory
136-1	RESPIRATORY MALIGNANCY	3.25	$33,000	No	0.4458	Respiratory	Respiratory
136-2	RESPIRATORY MALIGNANCY	4.20	$33,000	No	0.7139	Respiratory	Respiratory
136-3	RESPIRATORY MALIGNANCY	6.65	$34,412	No	1.1635	Respiratory	Respiratory
136-4	RESPIRATORY MALIGNANCY	9.45	$56,043	No	1.8352	Respiratory	Respiratory
137-1	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	4.70	$33,000	No	0.6367	Respiratory	Respiratory
137-2	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	5.30	$33,000	No	0.8482	Respiratory	Respiratory
137-3	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	7.24	$33,000	No	1.2031	Respiratory	Respiratory
137-4	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	10.34	$59,686	No	1.9132	Respiratory	Respiratory
138-1	BRONCHIOLITIS & RSV PNEUMONIA	2.39	$33,000	No	0.2804	Respiratory	Respiratory
138-2	BRONCHIOLITIS & RSV PNEUMONIA	3.12	$33,000	No	0.3844	Respiratory	Respiratory
138-3	BRONCHIOLITIS & RSV PNEUMONIA	5.34	$33,000	No	0.7518	Respiratory	Respiratory
138-4	BRONCHIOLITIS & RSV PNEUMONIA	9.14	$50,702	No	1.8352	Respiratory	Respiratory
139-1	OTHER PNEUMONIA	2.73	$33,000	No	0.4202	Respiratory	Respiratory
139-2	OTHER PNEUMONIA	3.78	$33,000	No	0.6402	Respiratory	Respiratory
139-3	OTHER PNEUMONIA	5.64	$33,000	No	0.9947	Respiratory	Respiratory
139-4	OTHER PNEUMONIA	8.72	$47,487	No	1.7261	Respiratory	Respiratory
140-1	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	3.11	$33,000	No	0.5252	Respiratory	Respiratory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
140-2	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	3.81	$33,000	No	0.6665	Respiratory	Respiratory
140-3	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5.19	$33,000	No	0.9076	Respiratory	Respiratory
140-4	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	8.75	$43,309	No	1.6690	Respiratory	Respiratory
141-1	ASTHMA	2.19	$33,000	No	0.3408	Respiratory	Respiratory
141-2	ASTHMA	3.07	$33,000	No	0.5015	Respiratory	Respiratory
141-3	ASTHMA	4.35	$33,000	No	0.7486	Respiratory	Respiratory
141-4	ASTHMA	5.60	$42,221	No	1.3503	Respiratory	Respiratory
142-1	INTERSTITIAL LUNG DISEASE	3.32	$33,000	No	0.5787	Respiratory	Respiratory
142-2	INTERSTITIAL LUNG DISEASE	4.22	$33,000	No	0.7445	Respiratory	Respiratory
142-3	INTERSTITIAL LUNG DISEASE	6.33	$39,713	No	1.0873	Respiratory	Respiratory
142-4	INTERSTITIAL LUNG DISEASE	10.35	$51,089	No	1.9559	Respiratory	Respiratory
143-1	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	2.86	$33,000	No	0.4353	Respiratory	Respiratory
143-2	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	3.77	$33,000	No	0.6616	Respiratory	Respiratory
143-3	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	5.65	$33,000	No	0.9962	Respiratory	Respiratory
143-4	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	8.63	$38,642	No	1.5730	Respiratory	Respiratory
144-1	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	2.16	$33,000	No	0.4363	Respiratory	Respiratory
144-2	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	2.95	$33,000	No	0.5598	Respiratory	Respiratory
144-3	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	4.29	$33,000	No	0.7748	Respiratory	Respiratory
144-4	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	7.23	$33,000	No	1.3057	Respiratory	Respiratory
160-1	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY	4.70	$66,544	No	3.1306	Miscellaneous	Circulatory
160-2	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY	6.17	$75,910	No	3.4602	Miscellaneous	Circulatory
160-3	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY	10.39	$98,000	No	5.0014	Miscellaneous	Circulatory
160-4	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY	26.06	$98,000	No	9.7328	Miscellaneous	Circulatory
161-1	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT	3.19	$70,678	No	4.0098	Miscellaneous	Circulatory
161-2	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT	7.87	$98,000	No	5.3013	Miscellaneous	Circulatory
161-3	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT	15.89	$98,000	No	8.4070	Miscellaneous	Circulatory
161-4	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT	31.03	$98,000	No	19.9842	Miscellaneous	Circulatory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
162-1	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION	8.01	$94,601	No	4.4218	Miscellaneous	Circulatory
162-2	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION	9.19	$98,000	No	4.9501	Miscellaneous	Circulatory
162-3	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION	13.23	$98,000	No	6.3338	Miscellaneous	Circulatory
162-4	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION	20.98	$98,000	No	9.6985	Miscellaneous	Circulatory
163-1	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION	5.67	$83,855	No	3.8077	Miscellaneous	Circulatory
163-2	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION	6.51	$92,405	No	4.2090	Miscellaneous	Circulatory
163-3	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION	9.25	$98,000	No	5.1794	Miscellaneous	Circulatory
163-4	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION	17.99	$98,000	No	8.8228	Miscellaneous	Circulatory
165-1	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	6.76	$77,694	No	3.8444	Miscellaneous	Circulatory
165-2	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	8.18	$98,000	No	4.3860	Miscellaneous	Circulatory
165-3	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	10.53	$76,887	No	5.3253	Miscellaneous	Circulatory
165-4	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	17.13	$98,000	No	8.0347	Miscellaneous	Circulatory
166-1	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	5.03	$60,759	No	3.0631	Miscellaneous	Circulatory
166-2	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	6.12	$84,567	No	3.4369	Miscellaneous	Circulatory
166-3	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	8.56	$98,000	No	4.2566	Miscellaneous	Circulatory
166-4	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE	16.15	$98,000	No	7.1276	Miscellaneous	Circulatory
167-1	OTHER CARDIOTHORACIC PROCEDURES	4.38	$62,971	No	2.8491	Miscellaneous	Circulatory
167-2	OTHER CARDIOTHORACIC PROCEDURES	5.83	$73,858	No	3.2690	Miscellaneous	Circulatory
167-3	OTHER CARDIOTHORACIC PROCEDURES	9.15	$98,000	No	4.1582	Miscellaneous	Circulatory
167-4	OTHER CARDIOTHORACIC PROCEDURES	18.60	$98,000	No	7.2603	Miscellaneous	Circulatory
169-1	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES	4.34	$38,022	No	1.7710	Miscellaneous	Circulatory
169-2	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES	5.70	$98,000	No	2.3017	Miscellaneous	Circulatory
169-3	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES	8.99	$91,011	No	3.5766	Miscellaneous	Circulatory
169-4	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES	16.26	$98,000	No	6.3593	Miscellaneous	Circulatory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
170-1	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	4.68	$51,433	No	2.2837	Miscellaneous	Circulatory
170-2	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	5.35	$53,142	No	2.4595	Miscellaneous	Circulatory
170-3	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	9.01	$67,152	No	3.0320	Miscellaneous	Circulatory
170-4	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	16.48	$98,000	No	4.8851	Miscellaneous	Circulatory
171-1	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	2.58	$34,713	No	1.6061	Miscellaneous	Circulatory
171-2	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	3.89	$49,549	No	1.9059	Miscellaneous	Circulatory
171-3	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	6.52	$65,476	No	2.4627	Miscellaneous	Circulatory
171-4	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	13.23	$98,000	No	4.2111	Miscellaneous	Circulatory
173-1	OTHER VASCULAR PROCEDURES	2.49	$35,070	No	1.7171	Miscellaneous	Circulatory
173-2	OTHER VASCULAR PROCEDURES	4.13	$52,565	No	2.0932	Miscellaneous	Circulatory
173-3	OTHER VASCULAR PROCEDURES	8.35	$69,343	No	2.8552	Miscellaneous	Circulatory
173-4	OTHER VASCULAR PROCEDURES	16.98	$98,000	No	5.2542	Miscellaneous	Circulatory
174-1	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI	2.43	$33,000	No	2.0862	Miscellaneous	Circulatory
174-2	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI	3.10	$35,643	No	2.2374	Miscellaneous	Circulatory
174-3	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI	5.33	$56,833	No	2.7863	Miscellaneous	Circulatory
174-4	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI	8.59	$98,000	No	4.0669	Miscellaneous	Circulatory
175-1	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI	1.72	$36,210	No	1.7736	Miscellaneous	Circulatory
175-2	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI	2.53	$36,979	No	1.9933	Miscellaneous	Circulatory
175-3	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI	5.17	$51,550	No	2.5842	Miscellaneous	Circulatory
175-4	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI	10.38	$98,000	No	4.2121	Miscellaneous	Circulatory
176-1	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT	2.91	$33,000	No	1.3019	Miscellaneous	Circulatory
176-2	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT	2.54	$59,783	No	2.4037	Miscellaneous	Circulatory
176-3	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT	4.47	$66,684	No	2.7424	Miscellaneous	Circulatory
176-4	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT	13.36	$98,000	No	4.5070	Miscellaneous	Circulatory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
177-1	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT	2.60	$33,000	No	1.0211	Miscellaneous	Circulatory
177-2	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT	4.05	$33,000	No	1.3637	Miscellaneous	Circulatory
177-3	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT	7.49	$53,290	No	2.1173	Miscellaneous	Circulatory
177-4	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT	15.60	$98,000	No	4.0225	Miscellaneous	Circulatory
180-1	OTHER CIRCULATORY SYSTEM PROCEDURES	4.16	$33,000	No	1.0497	Miscellaneous	Circulatory
180-2	OTHER CIRCULATORY SYSTEM PROCEDURES	5.93	$35,440	No	1.4143	Miscellaneous	Circulatory
180-3	OTHER CIRCULATORY SYSTEM PROCEDURES	9.63	$52,365	No	2.1255	Miscellaneous	Circulatory
180-4	OTHER CIRCULATORY SYSTEM PROCEDURES	15.89	$98,000	No	3.9764	Miscellaneous	Circulatory
190-1	ACUTE MYOCARDIAL INFARCTION	2.13	$33,000	No	0.6920	Miscellaneous	Circulatory
190-2	ACUTE MYOCARDIAL INFARCTION	3.15	$33,000	No	0.8341	Miscellaneous	Circulatory
190-3	ACUTE MYOCARDIAL INFARCTION	5.19	$33,000	No	1.1427	Miscellaneous	Circulatory
190-4	ACUTE MYOCARDIAL INFARCTION	7.65	$96,226	No	1.8575	Miscellaneous	Circulatory
191-1	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE	2.50	$33,000	No	1.0129	Miscellaneous	Circulatory
191-2	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE	3.57	$33,000	No	1.1962	Miscellaneous	Circulatory
191-3	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE	5.89	$33,000	No	1.5321	Miscellaneous	Circulatory
191-4	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE	11.58	$85,413	No	3.0798	Miscellaneous	Circulatory
192-1	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE	1.90	$33,000	No	0.8840	Miscellaneous	Circulatory
192-2	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE	2.57	$33,000	No	1.0294	Miscellaneous	Circulatory
192-3	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE	4.40	$33,000	No	1.3642	Miscellaneous	Circulatory
192-4	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE	7.34	$55,026	No	2.1517	Miscellaneous	Circulatory
193-1	ACUTE & SUBACUTE ENDOCARDITIS	5.50	$33,000	No	0.7894	Miscellaneous	Circulatory
193-2	ACUTE & SUBACUTE ENDOCARDITIS	6.95	$33,000	No	1.0373	Miscellaneous	Circulatory
193-3	ACUTE & SUBACUTE ENDOCARDITIS	10.02	$41,903	No	1.5660	Miscellaneous	Circulatory
193-4	ACUTE & SUBACUTE ENDOCARDITIS	14.92	$72,244	No	2.5224	Miscellaneous	Circulatory
194-1	HEART FAILURE	2.93	$33,000	No	0.5100	Miscellaneous	Circulatory
194-2	HEART FAILURE	3.75	$33,000	No	0.6549	Miscellaneous	Circulatory
194-3	HEART FAILURE	5.66	$33,000	No	0.9785	Miscellaneous	Circulatory
194-4	HEART FAILURE	9.56	$46,018	No	1.7820	Miscellaneous	Circulatory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
196-1	CARDIAC ARREST	2.92	$33,000	No	0.3448	Miscellaneous	Circulatory
196-2	CARDIAC ARREST	2.28	$33,000	No	0.4918	Miscellaneous	Circulatory
196-3	CARDIAC ARREST	2.52	$33,000	No	0.7133	Miscellaneous	Circulatory
196-4	CARDIAC ARREST	4.63	$41,091	No	1.7165	Miscellaneous	Circulatory
197-1	PERIPHERAL & OTHER VASCULAR DISORDERS	3.25	$33,000	No	0.4538	Miscellaneous	Circulatory
197-2	PERIPHERAL & OTHER VASCULAR DISORDERS	4.06	$33,000	No	0.6186	Miscellaneous	Circulatory
197-3	PERIPHERAL & OTHER VASCULAR DISORDERS	5.55	$33,000	No	0.9349	Miscellaneous	Circulatory
197-4	PERIPHERAL & OTHER VASCULAR DISORDERS	9.94	$54,973	No	1.8138	Miscellaneous	Circulatory
198-1	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	1.65	$33,000	No	0.4222	Miscellaneous	Circulatory
198-2	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	2.15	$33,000	No	0.5100	Miscellaneous	Circulatory
198-3	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	3.44	$33,000	No	0.6999	Miscellaneous	Circulatory
198-4	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	7.96	$41,164	No	1.3777	Miscellaneous	Circulatory
199-1	HYPERTENSION	1.99	$33,000	No	0.4431	Miscellaneous	Circulatory
199-2	HYPERTENSION	2.61	$33,000	No	0.5438	Miscellaneous	Circulatory
199-3	HYPERTENSION	4.08	$33,000	No	0.7709	Miscellaneous	Circulatory
199-4	HYPERTENSION	7.75	$41,996	No	1.6234	Miscellaneous	Circulatory
200-1	CARDIAC STRUCTURAL & VALVULAR DISORDERS	2.38	$33,000	No	0.4556	Miscellaneous	Circulatory
200-2	CARDIAC STRUCTURAL & VALVULAR DISORDERS	3.16	$33,000	No	0.5692	Miscellaneous	Circulatory
200-3	CARDIAC STRUCTURAL & VALVULAR DISORDERS	5.18	$33,000	No	0.8445	Miscellaneous	Circulatory
200-4	CARDIAC STRUCTURAL & VALVULAR DISORDERS	10.05	$55,187	No	1.6354	Miscellaneous	Circulatory
201-1	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	1.99	$33,000	No	0.4273	Miscellaneous	Circulatory
201-2	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	2.90	$33,000	No	0.5624	Miscellaneous	Circulatory
201-3	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	4.67	$33,000	No	0.8589	Miscellaneous	Circulatory
201-4	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	8.64	$60,979	No	1.7456	Miscellaneous	Circulatory
203-1	CHEST PAIN	1.48	$33,000	No	0.4179	Miscellaneous	Circulatory
203-2	CHEST PAIN	1.96	$33,000	No	0.5129	Miscellaneous	Circulatory
203-3	CHEST PAIN	3.06	$33,000	No	0.6846	Miscellaneous	Circulatory
203-4	CHEST PAIN	7.26	$37,910	No	1.3334	Miscellaneous	Circulatory

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
204-1	SYNCOPE & COLLAPSE	2.02	$33,000	No	0.4877	Miscellaneous	Circulatory
204-2	SYNCOPE & COLLAPSE	2.64	$33,000	No	0.5856	Miscellaneous	Circulatory
204-3	SYNCOPE & COLLAPSE	3.89	$33,000	No	0.7586	Miscellaneous	Circulatory
204-4	SYNCOPE & COLLAPSE	8.58	$39,588	No	1.5564	Miscellaneous	Circulatory
205-1	CARDIOMYOPATHY	2.38	$33,000	No	0.4349	Miscellaneous	Circulatory
205-2	CARDIOMYOPATHY	3.08	$33,000	No	0.5715	Miscellaneous	Circulatory
205-3	CARDIOMYOPATHY	4.97	$33,000	No	0.8342	Miscellaneous	Circulatory
205-4	CARDIOMYOPATHY	9.27	$58,727	No	1.8259	Miscellaneous	Circulatory
206-1	MALFUNCTION,REACTION,COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE	2.27	$33,000	No	0.4451	Miscellaneous	Circulatory
206-2	MALFUNCTION,REACTION,COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE	3.45	$33,000	No	0.5753	Miscellaneous	Circulatory
206-3	MALFUNCTION,REACTION,COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE	5.73	$33,000	No	0.9435	Miscellaneous	Circulatory
206-4	MALFUNCTION,REACTION,COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE	11.16	$35,046	No	2.0324	Miscellaneous	Circulatory
207-1	OTHER CIRCULATORY SYSTEM DIAGNOSES	2.40	$33,000	No	0.4971	Miscellaneous	Circulatory
207-2	OTHER CIRCULATORY SYSTEM DIAGNOSES	3.28	$33,000	No	0.6454	Miscellaneous	Circulatory
207-3	OTHER CIRCULATORY SYSTEM DIAGNOSES	4.80	$48,833	No	0.9118	Miscellaneous	Circulatory
207-4	OTHER CIRCULATORY SYSTEM DIAGNOSES	8.51	$35,066	No	1.7338	Miscellaneous	Circulatory
220-1	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	3.70	$33,000	No	1.3178	Miscellaneous	Gastroent
220-2	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	7.29	$40,153	No	1.9373	Miscellaneous	Gastroent
220-3	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	12.22	$77,022	No	3.1782	Miscellaneous	Gastroent
220-4	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	21.05	$98,000	No	5.9607	Miscellaneous	Gastroent
221-1	MAJOR SMALL & LARGE BOWEL PROCEDURES	4.87	$33,000	No	1.3985	Miscellaneous	Gastroent
221-2	MAJOR SMALL & LARGE BOWEL PROCEDURES	7.12	$50,016	No	1.8317	Miscellaneous	Gastroent
221-3	MAJOR SMALL & LARGE BOWEL PROCEDURES	12.16	$98,000	No	2.9391	Miscellaneous	Gastroent
221-4	MAJOR SMALL & LARGE BOWEL PROCEDURES	20.07	$98,000	No	5.5350	Miscellaneous	Gastroent
222-1	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	2.27	$33,000	No	0.8125	Miscellaneous	Gastroent

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
222-2	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	3.70	$48,849	No	1.2067	Miscellaneous	Gastroent
222-3	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	8.35	$51,735	No	1.9612	Miscellaneous	Gastroent
222-4	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	18.21	$98,000	No	4.4248	Miscellaneous	Gastroent
223-1	OTHER SMALL & LARGE BOWEL PROCEDURES	4.42	$33,000	No	1.0740	Miscellaneous	Gastroent
223-2	OTHER SMALL & LARGE BOWEL PROCEDURES	6.43	$48,603	No	1.4465	Miscellaneous	Gastroent
223-3	OTHER SMALL & LARGE BOWEL PROCEDURES	10.92	$53,067	No	2.3665	Miscellaneous	Gastroent
223-4	OTHER SMALL & LARGE BOWEL PROCEDURES	19.67	$98,000	No	4.9104	Miscellaneous	Gastroent
224-1	PERITONEAL ADHESIOLYSIS	5.41	$33,000	No	1.2216	Miscellaneous	Gastroent
224-2	PERITONEAL ADHESIOLYSIS	7.88	$43,821	No	1.6811	Miscellaneous	Gastroent
224-3	PERITONEAL ADHESIOLYSIS	11.50	$57,376	No	2.5159	Miscellaneous	Gastroent
224-4	PERITONEAL ADHESIOLYSIS	17.46	$98,000	No	4.4116	Miscellaneous	Gastroent
225-1	APPENDECTOMY	1.57	$33,000	No	0.7869	Miscellaneous	Gastroent
225-2	APPENDECTOMY	3.76	$33,000	No	1.1108	Miscellaneous	Gastroent
225-3	APPENDECTOMY	7.27	$42,939	No	1.8822	Miscellaneous	Gastroent
225-4	APPENDECTOMY	13.58	$88,159	No	3.6506	Miscellaneous	Gastroent
226-1	ANAL PROCEDURES	2.56	$33,000	No	0.6250	Miscellaneous	Gastroent
226-2	ANAL PROCEDURES	4.14	$33,000	No	0.8567	Miscellaneous	Gastroent
226-3	ANAL PROCEDURES	7.38	$35,497	No	1.3988	Miscellaneous	Gastroent
226-4	ANAL PROCEDURES	13.02	$74,432	No	2.8079	Miscellaneous	Gastroent
227-1	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL	2.90	$33,000	No	1.0044	Miscellaneous	Gastroent
227-2	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL	4.44	$33,000	No	1.3150	Miscellaneous	Gastroent
227-3	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL	8.14	$54,212	No	2.1598	Miscellaneous	Gastroent
227-4	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL	15.03	$98,000	No	4.3085	Miscellaneous	Gastroent
228-1	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES	2.01	$33,000	No	0.7221	Miscellaneous	Gastroent
228-2	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES	3.45	$33,000	No	0.9757	Miscellaneous	Gastroent
228-3	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES	6.29	$35,970	No	1.5210	Miscellaneous	Gastroent
228-4	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES	13.21	$84,887	No	3.2407	Miscellaneous	Gastroent
229-1	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES	3.87	$33,000	No	1.0849	Miscellaneous	Gastroent

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
229-2	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES	5.52	$33,000	No	1.4345	Miscellaneous	Gastroent
229-3	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES	9.76	$66,484	No	2.2850	Miscellaneous	Gastroent
229-4	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES	17.60	$98,000	No	4.2571	Miscellaneous	Gastroent
240-1	DIGESTIVE MALIGNANCY	3.71	$33,000	No	0.5526	Miscellaneous	Gastroent
240-2	DIGESTIVE MALIGNANCY	4.29	$33,000	No	0.7343	Miscellaneous	Gastroent
240-3	DIGESTIVE MALIGNANCY	6.85	$53,507	No	1.1112	Miscellaneous	Gastroent
240-4	DIGESTIVE MALIGNANCY	12.26	$36,452	No	2.0337	Miscellaneous	Gastroent
241-1	PEPTIC ULCER & GASTRITIS	2.52	$33,000	No	0.5506	Miscellaneous	Gastroent
241-2	PEPTIC ULCER & GASTRITIS	3.26	$33,000	No	0.7186	Miscellaneous	Gastroent
241-3	PEPTIC ULCER & GASTRITIS	4.85	$33,000	No	1.0583	Miscellaneous	Gastroent
241-4	PEPTIC ULCER & GASTRITIS	10.13	$59,869	No	2.3301	Miscellaneous	Gastroent
242-1	MAJOR ESOPHAGEAL DISORDERS	2.30	$33,000	No	0.5079	Miscellaneous	Gastroent
242-2	MAJOR ESOPHAGEAL DISORDERS	3.19	$33,000	No	0.6929	Miscellaneous	Gastroent
242-3	MAJOR ESOPHAGEAL DISORDERS	4.60	$33,000	No	1.0170	Miscellaneous	Gastroent
242-4	MAJOR ESOPHAGEAL DISORDERS	10.14	$39,347	No	2.2354	Miscellaneous	Gastroent
243-1	OTHER ESOPHAGEAL DISORDERS	1.90	$33,000	No	0.4492	Miscellaneous	Gastroent
243-2	OTHER ESOPHAGEAL DISORDERS	2.81	$33,000	No	0.6060	Miscellaneous	Gastroent
243-3	OTHER ESOPHAGEAL DISORDERS	4.79	$33,000	No	0.9094	Miscellaneous	Gastroent
243-4	OTHER ESOPHAGEAL DISORDERS	10.29	$43,948	No	2.0341	Miscellaneous	Gastroent
244-1	DIVERTICULITIS & DIVERTICULOSIS	2.93	$33,000	No	0.5246	Miscellaneous	Gastroent
244-2	DIVERTICULITIS & DIVERTICULOSIS	3.61	$33,000	No	0.6624	Miscellaneous	Gastroent
244-3	DIVERTICULITIS & DIVERTICULOSIS	5.45	$33,000	No	1.0053	Miscellaneous	Gastroent
244-4	DIVERTICULITIS & DIVERTICULOSIS	11.04	$55,836	No	2.1700	Miscellaneous	Gastroent
245-1	INFLAMMATORY BOWEL DISEASE	3.39	$33,000	No	0.5754	Miscellaneous	Gastroent
245-2	INFLAMMATORY BOWEL DISEASE	4.13	$33,000	No	0.7028	Miscellaneous	Gastroent
245-3	INFLAMMATORY BOWEL DISEASE	6.27	$33,000	No	1.0226	Miscellaneous	Gastroent
245-4	INFLAMMATORY BOWEL DISEASE	12.07	$50,424	No	1.9439	Miscellaneous	Gastroent
246-1	GASTROINTESTINAL VASCULAR INSUFFICIENCY	3.16	$33,000	No	0.6451	Miscellaneous	Gastroent
246-2	GASTROINTESTINAL VASCULAR INSUFFICIENCY	4.05	$33,000	No	0.7942	Miscellaneous	Gastroent
246-3	GASTROINTESTINAL VASCULAR INSUFFICIENCY	6.02	$33,000	No	1.1319	Miscellaneous	Gastroent
246-4	GASTROINTESTINAL VASCULAR INSUFFICIENCY	9.83	$53,702	No	1.9309	Miscellaneous	Gastroent

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
247-1	INTESTINAL OBSTRUCTION	2.89	$33,000	No	0.4874	Miscellaneous	Gastroent
247-2	INTESTINAL OBSTRUCTION	3.79	$33,000	No	0.6267	Miscellaneous	Gastroent
247-3	INTESTINAL OBSTRUCTION	5.96	$33,000	No	0.9525	Miscellaneous	Gastroent
247-4	INTESTINAL OBSTRUCTION	11.04	$56,422	No	1.9303	Miscellaneous	Gastroent
248-1	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS	3.34	$33,000	No	0.5084	Miscellaneous	Gastroent
248-2	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS	4.73	$33,000	No	0.7215	Miscellaneous	Gastroent
248-3	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS	7.10	$34,912	No	1.0667	Miscellaneous	Gastroent
248-4	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS	12.39	$69,502	No	2.0496	Miscellaneous	Gastroent
249-1	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	2.19	$33,000	No	0.3648	Miscellaneous	Gastroent
249-2	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	2.90	$33,000	No	0.5057	Miscellaneous	Gastroent
249-3	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	4.32	$33,000	No	0.7201	Miscellaneous	Gastroent
249-4	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	9.39	$33,000	No	1.5934	Miscellaneous	Gastroent
251-1	ABDOMINAL PAIN	2.17	$33,000	No	0.4492	Miscellaneous	Gastroent
251-2	ABDOMINAL PAIN	2.88	$33,000	No	0.5785	Miscellaneous	Gastroent
251-3	ABDOMINAL PAIN	4.19	$33,000	No	0.7857	Miscellaneous	Gastroent
251-4	ABDOMINAL PAIN	8.14	$41,765	No	1.4149	Miscellaneous	Gastroent
252-1	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	3.31	$33,000	No	0.4904	Miscellaneous	Gastroent
252-2	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	4.12	$33,000	No	0.6490	Miscellaneous	Gastroent
252-3	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	6.36	$33,000	No	0.9832	Miscellaneous	Gastroent
252-4	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	12.48	$98,000	No	1.9840	Miscellaneous	Gastroent
253-1	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	2.52	$33,000	No	0.5108	Miscellaneous	Gastroent
253-2	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	3.35	$33,000	No	0.6777	Miscellaneous	Gastroent
253-3	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	5.05	$33,000	No	1.0020	Miscellaneous	Gastroent
253-4	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	8.78	$47,996	No	1.8601	Miscellaneous	Gastroent
254-1	OTHER DIGESTIVE SYSTEM DIAGNOSES	2.52	$33,000	No	0.4518	Miscellaneous	Gastroent

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
254-2	OTHER DIGESTIVE SYSTEM DIAGNOSES	3.54	$33,000	No	0.6281	Miscellaneous	Gastroent
254-3	OTHER DIGESTIVE SYSTEM DIAGNOSES	5.30	$33,000	No	0.9116	Miscellaneous	Gastroent
254-4	OTHER DIGESTIVE SYSTEM DIAGNOSES	10.66	$47,268	No	1.8053	Miscellaneous	Gastroent
260-1	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	4.69	$38,091	No	1.5085	Miscellaneous	Gastroent
260-2	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	6.12	$59,063	No	1.9595	Miscellaneous	Gastroent
260-3	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	10.82	$98,000	No	3.1028	Miscellaneous	Gastroent
260-4	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	21.81	$98,000	No	6.3823	Miscellaneous	Gastroent
261-1	MAJOR BILIARY TRACT PROCEDURES	4.50	$33,000	No	1.3049	Miscellaneous	Gastroent
261-2	MAJOR BILIARY TRACT PROCEDURES	7.07	$42,516	No	1.8249	Miscellaneous	Gastroent
261-3	MAJOR BILIARY TRACT PROCEDURES	11.17	$62,635	No	2.5711	Miscellaneous	Gastroent
261-4	MAJOR BILIARY TRACT PROCEDURES	19.94	$98,000	No	5.0241	Miscellaneous	Gastroent
262-1	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC	4.06	$33,000	No	1.1851	Miscellaneous	Gastroent
262-2	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC	5.68	$40,595	No	1.5636	Miscellaneous	Gastroent
262-3	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC	8.99	$52,832	No	2.3607	Miscellaneous	Gastroent
262-4	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC	17.51	$98,000	No	4.6362	Miscellaneous	Gastroent
263-1	LAPAROSCOPIC CHOLECYSTECTOMY	2.37	$33,000	No	0.9344	Miscellaneous	Gastroent
263-2	LAPAROSCOPIC CHOLECYSTECTOMY	3.65	$33,000	No	1.2309	Miscellaneous	Gastroent
263-3	LAPAROSCOPIC CHOLECYSTECTOMY	6.36	$34,338	No	1.7676	Miscellaneous	Gastroent
263-4	LAPAROSCOPIC CHOLECYSTECTOMY	13.84	$90,246	No	3.6726	Miscellaneous	Gastroent
264-1	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES	4.54	$33,448	No	1.2525	Miscellaneous	Gastroent
264-2	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES	5.44	$33,000	No	1.3731	Miscellaneous	Gastroent
264-3	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES	10.68	$61,470	No	2.3158	Miscellaneous	Gastroent
264-4	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES	21.48	$98,000	No	5.1900	Miscellaneous	Gastroent
279-1	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	2.80	$33,000	No	0.4711	Miscellaneous	Gastroent
279-2	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	3.61	$33,000	No	0.5945	Miscellaneous	Gastroent
279-3	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	5.81	$33,000	No	0.9593	Miscellaneous	Gastroent
279-4	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	11.58	$62,382	No	2.3269	Miscellaneous	Gastroent
280-1	ALCOHOLIC LIVER DISEASE	2.99	$33,000	No	0.4733	Miscellaneous	Gastroent

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
280-2	ALCOHOLIC LIVER DISEASE	3.44	$33,000	No	0.6141	Miscellaneous	Gastroent
280-3	ALCOHOLIC LIVER DISEASE	5.33	$33,000	No	0.9717	Miscellaneous	Gastroent
280-4	ALCOHOLIC LIVER DISEASE	10.47	$48,708	No	2.1421	Miscellaneous	Gastroent
281-1	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	3.57	$33,000	No	0.5079	Miscellaneous	Gastroent
281-2	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	4.22	$33,000	No	0.7553	Miscellaneous	Gastroent
281-3	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	6.10	$33,000	No	1.0729	Miscellaneous	Gastroent
281-4	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	9.74	$33,000	No	1.7518	Miscellaneous	Gastroent
282-1	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	3.18	$33,000	No	0.5507	Miscellaneous	Gastroent
282-2	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	4.03	$33,000	No	0.7066	Miscellaneous	Gastroent
282-3	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	6.49	$33,000	No	1.1213	Miscellaneous	Gastroent
282-4	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	13.81	$77,977	No	2.7862	Miscellaneous	Gastroent
283-1	OTHER DISORDERS OF THE LIVER	2.86	$33,000	No	0.4912	Miscellaneous	Gastroent
283-2	OTHER DISORDERS OF THE LIVER	3.39	$33,000	No	0.6300	Miscellaneous	Gastroent
283-3	OTHER DISORDERS OF THE LIVER	5.05	$33,000	No	0.9245	Miscellaneous	Gastroent
283-4	OTHER DISORDERS OF THE LIVER	9.48	$50,739	No	1.8497	Miscellaneous	Gastroent
284-1	DISORDERS OF GALLBLADDER & BILIARY TRACT	2.45	$33,000	No	0.5402	Miscellaneous	Gastroent
284-2	DISORDERS OF GALLBLADDER & BILIARY TRACT	3.45	$33,000	No	0.7446	Miscellaneous	Gastroent
284-3	DISORDERS OF GALLBLADDER & BILIARY TRACT	5.36	$33,000	No	1.0803	Miscellaneous	Gastroent
284-4	DISORDERS OF GALLBLADDER & BILIARY TRACT	10.60	$59,886	No	2.1256	Miscellaneous	Gastroent
301-1	HIP JOINT REPLACEMENT	3.66	$33,000	No	1.8139	Miscellaneous	Miscellaneous
301-2	HIP JOINT REPLACEMENT	3.97	$34,978	No	1.9689	Miscellaneous	Miscellaneous
301-3	HIP JOINT REPLACEMENT	5.36	$73,021	No	2.5026	Miscellaneous	Miscellaneous
301-4	HIP JOINT REPLACEMENT	12.81	$93,920	No	3.9990	Miscellaneous	Miscellaneous
302-1	KNEE JOINT REPLACEMENT	2.96	$33,000	No	1.7428	Miscellaneous	Miscellaneous
302-2	KNEE JOINT REPLACEMENT	3.39	$34,481	No	1.9131	Miscellaneous	Miscellaneous
302-3	KNEE JOINT REPLACEMENT	5.20	$63,724	No	2.3798	Miscellaneous	Miscellaneous
302-4	KNEE JOINT REPLACEMENT	12.49	$98,000	No	4.3468	Miscellaneous	Miscellaneous
303-1	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK	4.51	$98,000	No	4.7039	Miscellaneous	Miscellaneous
303-2	DORSAL & LUMBAR FUSION PROC FOR	5.71	$98,000	No	5.5422	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
	CURVATURE OF BACK						
303-3	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK	8.57	$98,000	No	7.7549	Miscellaneous	Miscellaneous
303-4	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK	16.07	$98,000	No	10.5743	Miscellaneous	Miscellaneous
304-1	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	3.00	$50,366	No	2.9719	Miscellaneous	Miscellaneous
304-2	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	4.05	$71,945	No	3.5298	Miscellaneous	Miscellaneous
304-3	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	7.36	$98,000	No	4.9644	Miscellaneous	Miscellaneous
304-4	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	17.76	$98,000	No	8.1662	Miscellaneous	Miscellaneous
305-1	AMPUTATION OF LOWER LIMB EXCEPT TOES	5.41	$33,000	No	1.0653	Miscellaneous	Miscellaneous
305-2	AMPUTATION OF LOWER LIMB EXCEPT TOES	7.38	$33,000	No	1.4042	Miscellaneous	Miscellaneous
305-3	AMPUTATION OF LOWER LIMB EXCEPT TOES	11.38	$43,479	No	2.1842	Miscellaneous	Miscellaneous
305-4	AMPUTATION OF LOWER LIMB EXCEPT TOES	19.88	$80,033	No	4.2155	Miscellaneous	Miscellaneous
308-1	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT	4.19	$33,000	No	1.3100	Miscellaneous	Miscellaneous
308-2	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT	4.96	$33,000	No	1.5854	Miscellaneous	Miscellaneous
308-3	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT	6.98	$62,321	No	2.1517	Miscellaneous	Miscellaneous
308-4	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT	12.65	$98,000	No	3.6506	Miscellaneous	Miscellaneous
309-1	HIP & FEMUR PROCEDURES FOR NON-TRAUMA EXCEPT JOINT REPLACEMENT	2.78	$33,000	No	1.1481	Miscellaneous	Miscellaneous
309-2	HIP & FEMUR PROCEDURES FOR NON-TRAUMA EXCEPT JOINT REPLACEMENT	4.91	$33,000	No	1.6231	Miscellaneous	Miscellaneous
309-3	HIP & FEMUR PROCEDURES FOR NON-TRAUMA EXCEPT JOINT REPLACEMENT	8.66	$74,835	No	2.3287	Miscellaneous	Miscellaneous
309-4	HIP & FEMUR PROCEDURES FOR NON-TRAUMA EXCEPT JOINT REPLACEMENT	18.87	$98,000	No	4.2408	Miscellaneous	Miscellaneous
310-1	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION	1.81	$33,000	No	0.8925	Miscellaneous	Miscellaneous
310-2	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION	3.03	$33,000	No	1.1887	Miscellaneous	Miscellaneous
310-3	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION	6.25	$61,320	No	1.7910	Miscellaneous	Miscellaneous
310-4	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION	16.23	$98,000	No	4.1661	Miscellaneous	Miscellaneous
312-1	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES	5.39	$36,347	No	1.2554	Miscellaneous	Miscellaneous
312-2	SKIN GRAFT, EXCEPT HAND, FOR	9.40	$52,640	No	1.8446	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
	MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES						
312-3	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES	18.47	$82,391	No	3.1355	Miscellaneous	Miscellaneous
312-4	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES	32.85	$98,000	No	7.1147	Miscellaneous	Miscellaneous
313-1	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT	2.70	$33,000	No	1.0852	Miscellaneous	Miscellaneous
313-2	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT	4.44	$45,267	No	1.5212	Miscellaneous	Miscellaneous
313-3	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT	7.86	$55,898	No	2.2742	Miscellaneous	Miscellaneous
313-4	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT	16.60	$98,000	No	4.3349	Miscellaneous	Miscellaneous
314-1	FOOT & TOE PROCEDURES	2.58	$33,000	No	0.9291	Miscellaneous	Miscellaneous
314-2	FOOT & TOE PROCEDURES	5.08	$33,000	No	1.1319	Miscellaneous	Miscellaneous
314-3	FOOT & TOE PROCEDURES	8.10	$34,744	No	1.6006	Miscellaneous	Miscellaneous
314-4	FOOT & TOE PROCEDURES	15.79	$90,039	No	3.2885	Miscellaneous	Miscellaneous
315-1	SHOULDER, UPPER ARM & FOREARM PROCEDURES	1.85	$33,000	No	0.8387	Miscellaneous	Miscellaneous
315-2	SHOULDER, UPPER ARM & FOREARM PROCEDURES	2.68	$38,079	No	1.5911	Miscellaneous	Miscellaneous
315-3	SHOULDER, UPPER ARM & FOREARM PROCEDURES	6.50	$67,500	No	2.2542	Miscellaneous	Miscellaneous
315-4	SHOULDER, UPPER ARM & FOREARM PROCEDURES	14.73	$98,000	No	4.4542	Miscellaneous	Miscellaneous
316-1	HAND & WRIST PROCEDURES	2.29	$33,000	No	0.7195	Miscellaneous	Miscellaneous
316-2	HAND & WRIST PROCEDURES	3.96	$33,000	No	1.0563	Miscellaneous	Miscellaneous
316-3	HAND & WRIST PROCEDURES	7.28	$44,461	No	1.7143	Miscellaneous	Miscellaneous
316-4	HAND & WRIST PROCEDURES	14.30	$89,465	No	3.4567	Miscellaneous	Miscellaneous
317-1	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES	3.00	$33,000	No	0.8204	Miscellaneous	Miscellaneous
317-2	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES	5.45	$41,176	No	1.1763	Miscellaneous	Miscellaneous
317-3	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES	10.31	$57,003	No	1.9738	Miscellaneous	Miscellaneous
317-4	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES	20.38	$98,000	No	4.3377	Miscellaneous	Miscellaneous
320-1	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	2.29	$33,000	No	0.9313	Miscellaneous	Miscellaneous
320-2	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	4.74	$46,811	No	1.4085	Miscellaneous	Miscellaneous
320-3	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	9.00	$53,357	No	2.1497	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
320-4	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	18.44	$98,000	No	4.0942	Miscellaneous	Miscellaneous
321-1	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	1.74	$33,332	No	1.6799	Miscellaneous	Miscellaneous
321-2	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	3.23	$54,567	No	2.1291	Miscellaneous	Miscellaneous
321-3	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	8.70	$98,000	No	3.5736	Miscellaneous	Miscellaneous
321-4	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	17.40	$98,000	No	6.5431	Miscellaneous	Miscellaneous
340-1	FRACTURE OF FEMUR	3.07	$33,000	No	0.4052	Miscellaneous	Miscellaneous
340-2	FRACTURE OF FEMUR	3.51	$33,000	No	0.5212	Miscellaneous	Miscellaneous
340-3	FRACTURE OF FEMUR	5.08	$33,000	No	0.7741	Miscellaneous	Miscellaneous
340-4	FRACTURE OF FEMUR	7.18	$40,631	No	1.3544	Miscellaneous	Miscellaneous
341-1	FRACTURE OF PELVIS OR DISLOCATION OF HIP	3.02	$33,000	No	0.4685	Miscellaneous	Miscellaneous
341-2	FRACTURE OF PELVIS OR DISLOCATION OF HIP	3.65	$33,000	No	0.5732	Miscellaneous	Miscellaneous
341-3	FRACTURE OF PELVIS OR DISLOCATION OF HIP	4.80	$33,000	No	0.7834	Miscellaneous	Miscellaneous
341-4	FRACTURE OF PELVIS OR DISLOCATION OF HIP	9.82	$51,616	No	1.9346	Miscellaneous	Miscellaneous
342-1	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	2.24	$33,000	No	0.4198	Miscellaneous	Miscellaneous
342-2	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	3.36	$33,000	No	0.6015	Miscellaneous	Miscellaneous
342-3	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	5.23	$33,000	No	0.9030	Miscellaneous	Miscellaneous
342-4	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	10.73	$53,772	No	1.9467	Miscellaneous	Miscellaneous
343-1	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG	3.82	$33,000	No	0.6312	Miscellaneous	Miscellaneous
343-2	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG	4.63	$33,000	No	0.7918	Miscellaneous	Miscellaneous
343-3	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG	7.68	$33,582	No	1.2981	Miscellaneous	Miscellaneous
343-4	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG	12.78	$61,927	No	2.2511	Miscellaneous	Miscellaneous
344-1	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	5.10	$33,000	No	0.6188	Miscellaneous	Miscellaneous
344-2	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	6.24	$33,000	No	0.8269	Miscellaneous	Miscellaneous
344-3	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	9.97	$36,841	No	1.2368	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
344-4	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	17.27	$79,789	No	2.0625	Miscellaneous	Miscellaneous
346-1	CONNECTIVE TISSUE DISORDERS	3.13	$33,000	No	0.5245	Miscellaneous	Miscellaneous
346-2	CONNECTIVE TISSUE DISORDERS	4.18	$55,153	No	0.7180	Miscellaneous	Miscellaneous
346-3	CONNECTIVE TISSUE DISORDERS	7.43	$33,000	No	1.2230	Miscellaneous	Miscellaneous
346-4	CONNECTIVE TISSUE DISORDERS	15.07	$92,159	No	2.9853	Miscellaneous	Miscellaneous
347-1	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	2.89	$33,000	No	0.5201	Miscellaneous	Miscellaneous
347-2	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	3.88	$33,000	No	0.7037	Miscellaneous	Miscellaneous
347-3	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	5.34	$33,000	No	0.9894	Miscellaneous	Miscellaneous
347-4	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	11.84	$60,582	No	2.3176	Miscellaneous	Miscellaneous
349-1	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	2.27	$33,000	No	0.4380	Miscellaneous	Miscellaneous
349-2	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	4.81	$33,000	No	0.6458	Miscellaneous	Miscellaneous
349-3	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	8.07	$33,425	No	1.0302	Miscellaneous	Miscellaneous
349-4	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	13.87	$61,222	No	1.9260	Miscellaneous	Miscellaneous
351-1	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	2.53	$33,000	No	0.4073	Miscellaneous	Miscellaneous
351-2	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	3.52	$33,000	No	0.5668	Miscellaneous	Miscellaneous
351-3	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	5.44	$33,000	No	0.8930	Miscellaneous	Miscellaneous
351-4	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	11.12	$50,591	No	1.9108	Miscellaneous	Miscellaneous
361-1	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES	4.07	$33,000	No	1.1096	Miscellaneous	Miscellaneous
361-2	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES	7.59	$49,403	No	1.4459	Miscellaneous	Miscellaneous
361-3	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES	13.93	$59,947	No	2.1415	Miscellaneous	Miscellaneous
361-4	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES	28.57	$98,000	No	4.5411	Miscellaneous	Miscellaneous
362-1	MASTECTOMY PROCEDURES	1.80	$33,000	No	1.0090	Miscellaneous	Miscellaneous
362-2	MASTECTOMY PROCEDURES	2.33	$41,240	No	1.3553	Miscellaneous	Miscellaneous
362-3	MASTECTOMY PROCEDURES	5.98	$45,892	No	1.7862	Miscellaneous	Miscellaneous
362-4	MASTECTOMY PROCEDURES	13.81	$98,000	No	3.8257	Miscellaneous	Miscellaneous
363-1	BREAST PROCEDURES EXCEPT MASTECTOMY	2.10	$33,000	No	0.8797	Miscellaneous	Miscellaneous
363-2	BREAST PROCEDURES EXCEPT MASTECTOMY	3.14	$37,443	No	1.4900	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
363-3	BREAST PROCEDURES EXCEPT MASTECTOMY	5.32	$55,292	No	1.9039	Miscellaneous	Miscellaneous
363-4	BREAST PROCEDURES EXCEPT MASTECTOMY	17.06	$98,000	No	3.5420	Miscellaneous	Miscellaneous
364-1	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES	2.89	$33,000	No	0.7644	Miscellaneous	Miscellaneous
364-2	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES	5.09	$33,000	No	1.0877	Miscellaneous	Miscellaneous
364-3	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES	9.44	$54,058	No	1.6986	Miscellaneous	Miscellaneous
364-4	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES	19.20	$98,000	No	3.0642	Miscellaneous	Miscellaneous
380-1	SKIN ULCERS	4.17	$33,000	No	0.5289	Miscellaneous	Miscellaneous
380-2	SKIN ULCERS	4.98	$33,000	No	0.6545	Miscellaneous	Miscellaneous
380-3	SKIN ULCERS	7.84	$33,000	No	0.9424	Miscellaneous	Miscellaneous
380-4	SKIN ULCERS	16.62	$89,395	No	1.7199	Miscellaneous	Miscellaneous
381-1	MAJOR SKIN DISORDERS	3.00	$33,000	No	0.3883	Miscellaneous	Miscellaneous
381-2	MAJOR SKIN DISORDERS	4.29	$33,000	No	0.5747	Miscellaneous	Miscellaneous
381-3	MAJOR SKIN DISORDERS	6.71	$33,000	No	0.9734	Miscellaneous	Miscellaneous
381-4	MAJOR SKIN DISORDERS	14.06	$96,473	No	2.7512	Miscellaneous	Miscellaneous
382-1	MALIGNANT BREAST DISORDERS	3.81	$33,000	No	0.3521	Miscellaneous	Miscellaneous
382-2	MALIGNANT BREAST DISORDERS	4.32	$33,000	No	0.5612	Miscellaneous	Miscellaneous
382-3	MALIGNANT BREAST DISORDERS	6.45	$33,000	No	0.9634	Miscellaneous	Miscellaneous
382-4	MALIGNANT BREAST DISORDERS	10.04	$53,520	No	1.5729	Miscellaneous	Miscellaneous
383-1	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	2.95	$33,000	No	0.4148	Miscellaneous	Miscellaneous
383-2	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	4.13	$33,000	No	0.5905	Miscellaneous	Miscellaneous
383-3	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	6.17	$33,000	No	0.9147	Miscellaneous	Miscellaneous
383-4	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	11.99	$51,724	No	1.9560	Miscellaneous	Miscellaneous
384-1	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	1.93	$33,000	No	0.4751	Miscellaneous	Miscellaneous
384-2	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	3.01	$33,000	No	0.6220	Miscellaneous	Miscellaneous
384-3	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	4.93	$33,000	No	0.8932	Miscellaneous	Miscellaneous
384-4	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	11.35	$58,366	No	2.0168	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
385-1	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	2.49	$33,000	No	0.3495	Miscellaneous	Miscellaneous
385-2	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	3.54	$33,000	No	0.5103	Miscellaneous	Miscellaneous
385-3	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	5.65	$33,000	No	0.7973	Miscellaneous	Miscellaneous
385-4	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	12.95	$64,697	No	1.9127	Miscellaneous	Miscellaneous
401-1	PITUITARY & ADRENAL PROCEDURES	3.04	$33,000	No	1.3697	Miscellaneous	Miscellaneous
401-2	PITUITARY & ADRENAL PROCEDURES	4.27	$43,515	No	1.8346	Miscellaneous	Miscellaneous
401-3	PITUITARY & ADRENAL PROCEDURES	8.45	$73,279	No	2.9058	Miscellaneous	Miscellaneous
401-4	PITUITARY & ADRENAL PROCEDURES	24.52	$98,000	No	7.1913	Miscellaneous	Miscellaneous
403-1	PROCEDURES FOR OBESITY	1.84	$37,118	No	1.2812	Miscellaneous	Miscellaneous
403-2	PROCEDURES FOR OBESITY	2.23	$44,656	No	1.4411	Miscellaneous	Miscellaneous
403-3	PROCEDURES FOR OBESITY	4.97	$50,526	No	2.1530	Miscellaneous	Miscellaneous
403-4	PROCEDURES FOR OBESITY	18.67	$98,000	No	6.1151	Miscellaneous	Miscellaneous
404-1	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES	1.31	$33,000	No	0.7364	Miscellaneous	Miscellaneous
404-2	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES	2.17	$33,000	No	0.9479	Miscellaneous	Miscellaneous
404-3	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES	6.59	$48,997	No	1.8990	Miscellaneous	Miscellaneous
404-4	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES	16.38	$98,000	No	4.2519	Miscellaneous	Miscellaneous
405-1	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS	4.19	$33,000	No	1.1123	Miscellaneous	Miscellaneous
405-2	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS	5.71	$35,671	No	1.4210	Miscellaneous	Miscellaneous
405-3	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS	9.66	$59,097	No	2.1421	Miscellaneous	Miscellaneous
405-4	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS	21.31	$98,000	No	4.8796	Miscellaneous	Miscellaneous
420-1	DIABETES	2.61	$33,000	No	0.3896	Miscellaneous	Miscellaneous
420-2	DIABETES	2.76	$33,000	No	0.5301	Miscellaneous	Miscellaneous
420-3	DIABETES	4.28	$33,000	No	0.7861	Miscellaneous	Miscellaneous
420-4	DIABETES	9.35	$89,964	No	1.9671	Miscellaneous	Miscellaneous
421-1	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS	3.52	$33,000	No	0.3210	Miscellaneous	Miscellaneous
421-2	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS	4.83	$33,000	No	0.5226	Miscellaneous	Miscellaneous
421-3	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS	6.76	$33,000	No	0.8189	Miscellaneous	Miscellaneous
421-4	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS	13.76	$85,517	No	1.7445	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
422-1	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS	2.00	$33,000	No	0.2847	Miscellaneous	Miscellaneous
422-2	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS	2.92	$33,000	No	0.4625	Miscellaneous	Miscellaneous
422-3	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS	4.45	$40,637	No	0.6828	Miscellaneous	Miscellaneous
422-4	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS	9.15	$64,843	No	1.4444	Miscellaneous	Miscellaneous
423-1	INBORN ERRORS OF METABOLISM	2.73	$33,000	No	0.4421	Miscellaneous	Miscellaneous
423-2	INBORN ERRORS OF METABOLISM	3.64	$33,000	No	0.5846	Miscellaneous	Miscellaneous
423-3	INBORN ERRORS OF METABOLISM	5.73	$61,814	No	0.9539	Miscellaneous	Miscellaneous
423-4	INBORN ERRORS OF METABOLISM	15.04	$87,800	No	2.7384	Miscellaneous	Miscellaneous
424-1	OTHER ENDOCRINE DISORDERS	2.59	$33,000	No	0.4341	Miscellaneous	Miscellaneous
424-2	OTHER ENDOCRINE DISORDERS	3.98	$33,000	No	0.6514	Miscellaneous	Miscellaneous
424-3	OTHER ENDOCRINE DISORDERS	6.05	$33,000	No	0.9767	Miscellaneous	Miscellaneous
424-4	OTHER ENDOCRINE DISORDERS	11.48	$57,886	No	2.1520	Miscellaneous	Miscellaneous
425-1	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED	2.42	$33,000	No	0.4017	Miscellaneous	Miscellaneous
425-2	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED	3.03	$33,000	No	0.5131	Miscellaneous	Miscellaneous
425-3	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED	4.61	$33,000	No	0.7666	Miscellaneous	Miscellaneous
425-4	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED	9.46	$47,486	No	1.6767	Miscellaneous	Miscellaneous
440-1	KIDNEY TRANSPLANT	4.58	$98,000	No	4.4667	Miscellaneous	Miscellaneous
440-2	KIDNEY TRANSPLANT	5.62	$98,000	No	5.0077	Miscellaneous	Miscellaneous
440-3	KIDNEY TRANSPLANT	8.64	$98,000	No	6.0561	Miscellaneous	Miscellaneous
440-4	KIDNEY TRANSPLANT	20.88	$98,000	No	9.9171	Miscellaneous	Miscellaneous
441-1	MAJOR BLADDER PROCEDURES	4.74	$33,000	No	1.4386	Miscellaneous	Miscellaneous
441-2	MAJOR BLADDER PROCEDURES	7.27	$53,491	No	2.1566	Miscellaneous	Miscellaneous
441-3	MAJOR BLADDER PROCEDURES	9.95	$67,771	No	2.9549	Miscellaneous	Miscellaneous
441-4	MAJOR BLADDER PROCEDURES	21.97	$98,000	No	6.1841	Miscellaneous	Miscellaneous
442-1	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY	3.25	$33,000	No	1.3138	Miscellaneous	Miscellaneous
442-2	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY	4.22	$38,954	No	1.5537	Miscellaneous	Miscellaneous
442-3	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY	7.95	$44,716	No	2.3455	Miscellaneous	Miscellaneous
442-4	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY	16.72	$98,000	No	4.9225	Miscellaneous	Miscellaneous
443-1	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY	2.54	$33,000	No	1.0883	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
443-2	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY	3.56	$37,144	No	1.2833	Miscellaneous	Miscellaneous
443-3	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY	8.02	$52,618	No	1.8814	Miscellaneous	Miscellaneous
443-4	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY	17.52	$98,000	No	4.0742	Miscellaneous	Miscellaneous
444-1	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY	2.64	$33,000	No	0.9409	Miscellaneous	Miscellaneous
444-2	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY	4.47	$33,000	No	1.2604	Miscellaneous	Miscellaneous
444-3	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY	9.34	$44,311	No	2.0686	Miscellaneous	Miscellaneous
444-4	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY	16.17	$98,000	No	3.8829	Miscellaneous	Miscellaneous
445-1	OTHER BLADDER PROCEDURES	1.90	$33,000	No	0.8552	Miscellaneous	Miscellaneous
445-2	OTHER BLADDER PROCEDURES	3.19	$33,000	No	1.1609	Miscellaneous	Miscellaneous
445-3	OTHER BLADDER PROCEDURES	7.81	$43,245	No	1.5964	Miscellaneous	Miscellaneous
445-4	OTHER BLADDER PROCEDURES	15.45	$82,023	No	3.1569	Miscellaneous	Miscellaneous
446-1	URETHRAL & TRANSURETHRAL PROCEDURES	1.89	$33,000	No	0.6757	Miscellaneous	Miscellaneous
446-2	URETHRAL & TRANSURETHRAL PROCEDURES	2.62	$33,000	No	0.8689	Miscellaneous	Miscellaneous
446-3	URETHRAL & TRANSURETHRAL PROCEDURES	6.13	$34,738	No	1.4201	Miscellaneous	Miscellaneous
446-4	URETHRAL & TRANSURETHRAL PROCEDURES	13.63	$74,615	No	3.0173	Miscellaneous	Miscellaneous
447-1	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES	2.29	$33,000	No	1.1479	Miscellaneous	Miscellaneous
447-2	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES	3.65	$74,801	No	1.3293	Miscellaneous	Miscellaneous
447-3	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES	7.28	$48,297	No	1.9661	Miscellaneous	Miscellaneous
447-4	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES	17.87	$98,000	No	4.3932	Miscellaneous	Miscellaneous
460-1	RENAL FAILURE	3.00	$33,000	No	0.4323	Miscellaneous	Miscellaneous
460-2	RENAL FAILURE	3.77	$33,000	No	0.6060	Miscellaneous	Miscellaneous
460-3	RENAL FAILURE	4.97	$33,000	No	0.7895	Miscellaneous	Miscellaneous
460-4	RENAL FAILURE	11.15	$80,603	No	1.9936	Miscellaneous	Miscellaneous
461-1	KIDNEY & URINARY TRACT MALIGNANCY	2.72	$33,000	No	0.4315	Miscellaneous	Miscellaneous
461-2	KIDNEY & URINARY TRACT MALIGNANCY	3.75	$33,000	No	0.5992	Miscellaneous	Miscellaneous
461-3	KIDNEY & URINARY TRACT MALIGNANCY	6.02	$33,000	No	0.9498	Miscellaneous	Miscellaneous
461-4	KIDNEY & URINARY TRACT MALIGNANCY	11.09	$54,020	No	1.6929	Miscellaneous	Miscellaneous
462-1	NEPHRITIS & NEPHROSIS	2.60	$33,000	No	0.3798	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
462-2	NEPHRITIS & NEPHROSIS	3.70	$33,000	No	0.5297	Miscellaneous	Miscellaneous
462-3	NEPHRITIS & NEPHROSIS	6.57	$33,000	No	0.9438	Miscellaneous	Miscellaneous
462-4	NEPHRITIS & NEPHROSIS	13.60	$63,364	No	2.3904	Miscellaneous	Miscellaneous
463-1	KIDNEY & URINARY TRACT INFECTIONS	2.69	$33,000	No	0.4120	Miscellaneous	Miscellaneous
463-2	KIDNEY & URINARY TRACT INFECTIONS	3.52	$33,000	No	0.5627	Miscellaneous	Miscellaneous
463-3	KIDNEY & URINARY TRACT INFECTIONS	5.07	$33,000	No	0.7878	Miscellaneous	Miscellaneous
463-4	KIDNEY & URINARY TRACT INFECTIONS	9.10	$39,245	No	1.4066	Miscellaneous	Miscellaneous
465-1	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	1.65	$33,000	No	0.4374	Miscellaneous	Miscellaneous
465-2	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	2.03	$33,000	No	0.5548	Miscellaneous	Miscellaneous
465-3	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	3.80	$33,000	No	0.8751	Miscellaneous	Miscellaneous
465-4	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	8.60	$45,544	No	1.8921	Miscellaneous	Miscellaneous
466-1	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	2.22	$33,000	No	0.3576	Miscellaneous	Miscellaneous
466-2	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	3.43	$33,000	No	0.5752	Miscellaneous	Miscellaneous
466-3	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	5.34	$33,000	No	0.8973	Miscellaneous	Miscellaneous
466-4	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	9.71	$48,112	No	1.7498	Miscellaneous	Miscellaneous
468-1	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	2.47	$33,000	No	0.4151	Miscellaneous	Miscellaneous
468-2	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	3.36	$33,000	No	0.5934	Miscellaneous	Miscellaneous
468-3	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	5.10	$33,000	No	0.8697	Miscellaneous	Miscellaneous
468-4	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	10.57	$38,589	No	1.8660	Miscellaneous	Miscellaneous
480-1	MAJOR MALE PELVIC PROCEDURES	1.80	$33,000	No	1.2119	Miscellaneous	Miscellaneous
480-2	MAJOR MALE PELVIC PROCEDURES	2.42	$33,000	No	1.3476	Miscellaneous	Miscellaneous
480-3	MAJOR MALE PELVIC PROCEDURES	6.18	$48,495	No	2.0991	Miscellaneous	Miscellaneous
480-4	MAJOR MALE PELVIC PROCEDURES	14.22	$98,000	No	4.5258	Miscellaneous	Miscellaneous
481-1	PENIS PROCEDURES	2.29	$33,000	No	0.6793	Miscellaneous	Miscellaneous
481-2	PENIS PROCEDURES	2.68	$33,000	No	1.1921	Miscellaneous	Miscellaneous
481-3	PENIS PROCEDURES	8.30	$45,188	No	1.7938	Miscellaneous	Miscellaneous
481-4	PENIS PROCEDURES	18.11	$98,000	No	4.1143	Miscellaneous	Miscellaneous
482-1	TRANSURETHRAL PROSTATECTOMY	1.70	$33,000	No	0.5917	Miscellaneous	Miscellaneous
482-2	TRANSURETHRAL PROSTATECTOMY	2.79	$33,000	No	0.7555	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
482-3	TRANSURETHRAL PROSTATECTOMY	7.16	$35,168	No	1.4662	Miscellaneous	Miscellaneous
482-4	TRANSURETHRAL PROSTATECTOMY	13.42	$72,594	No	3.0716	Miscellaneous	Miscellaneous
483-1	TESTES & SCROTAL PROCEDURES	2.04	$33,000	No	0.6074	Miscellaneous	Miscellaneous
483-2	TESTES & SCROTAL PROCEDURES	5.41	$33,000	No	1.1326	Miscellaneous	Miscellaneous
483-3	TESTES & SCROTAL PROCEDURES	11.27	$54,662	No	2.2017	Miscellaneous	Miscellaneous
483-4	TESTES & SCROTAL PROCEDURES	19.70	$98,000	No	4.4243	Miscellaneous	Miscellaneous
484-1	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	2.50	$33,000	No	0.7704	Miscellaneous	Miscellaneous
484-2	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	1.91	$33,000	No	1.1762	Miscellaneous	Miscellaneous
484-3	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	5.03	$35,917	No	1.5177	Miscellaneous	Miscellaneous
484-4	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	15.79	$81,598	No	3.6554	Miscellaneous	Miscellaneous
500-1	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	2.66	$33,000	No	0.3789	Miscellaneous	Miscellaneous
500-2	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	4.32	$33,000	No	0.5903	Miscellaneous	Miscellaneous
500-3	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	6.02	$33,000	No	0.9171	Miscellaneous	Miscellaneous
500-4	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	11.09	$48,987	No	1.7461	Miscellaneous	Miscellaneous
501-1	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	2.59	$33,000	No	0.4044	Miscellaneous	Miscellaneous
501-2	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	3.52	$33,000	No	0.5541	Miscellaneous	Miscellaneous
501-3	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	5.48	$33,000	No	0.8321	Miscellaneous	Miscellaneous
501-4	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	10.75	$45,981	No	1.6765	Miscellaneous	Miscellaneous
510-1	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS	2.45	$53,220	No	1.1433	Miscellaneous	Miscellaneous
510-2	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS	3.87	$58,399	No	1.4140	Miscellaneous	Miscellaneous
510-3	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS	8.93	$65,673	No	2.5806	Miscellaneous	Miscellaneous
510-4	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS	17.87	$98,000	No	5.2317	Miscellaneous	Miscellaneous
511-1	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY	3.30	$33,000	No	1.1911	Miscellaneous	Miscellaneous
511-2	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY	4.89	$34,289	No	1.4922	Miscellaneous	Miscellaneous
511-3	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY	8.62	$53,324	No	2.2750	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
511-4	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY	17.78	$98,000	No	4.9887	Miscellaneous	Miscellaneous
512-1	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG	2.18	$33,000	No	1.0602	Miscellaneous	Miscellaneous
512-2	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG	3.08	$33,000	No	1.2409	Miscellaneous	Miscellaneous
512-3	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG	6.83	$46,662	No	1.9879	Miscellaneous	Miscellaneous
512-4	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG	16.30	$98,000	No	4.5702	Miscellaneous	Miscellaneous
513-1	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA	1.87	$33,000	No	0.8514	Miscellaneous	Miscellaneous
513-2	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA	2.52	$33,000	No	1.0025	Miscellaneous	Miscellaneous
513-3	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA	5.65	$47,899	No	1.6282	Miscellaneous	Miscellaneous
513-4	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA	15.08	$98,000	No	4.0387	Miscellaneous	Miscellaneous
514-1	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.40	$33,000	No	0.7297	Miscellaneous	Miscellaneous
514-2	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.72	$33,000	No	0.9617	Miscellaneous	Miscellaneous
514-3	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	5.29	$38,282	No	1.5881	Miscellaneous	Miscellaneous
514-4	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	15.58	$98,000	No	4.0690	Miscellaneous	Miscellaneous
517-1	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES	1.93	$33,000	No	0.6030	Miscellaneous	Miscellaneous
517-2	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES	2.89	$33,000	No	0.8035	Miscellaneous	Miscellaneous
517-3	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES	6.64	$35,468	No	1.3632	Miscellaneous	Miscellaneous
517-4	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES	13.64	$70,788	No	2.9709	Miscellaneous	Miscellaneous
518-1	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	2.23	$33,000	No	0.6924	Miscellaneous	Miscellaneous
518-2	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	3.82	$33,591	No	1.0039	Miscellaneous	Miscellaneous
518-3	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	8.37	$47,076	No	1.8032	Miscellaneous	Miscellaneous
518-4	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	18.28	$98,000	No	4.4555	Miscellaneous	Miscellaneous
519-1	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA	2.07	$33,000	No	0.8286	Miscellaneous	Miscellaneous
519-2	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA	2.79	$33,000	No	1.0051	Miscellaneous	Miscellaneous
519-3	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA	6.13	$40,404	No	1.7505	Miscellaneous	Miscellaneous
519-4	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA	14.85	$98,000	No	3.9432	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
530-1	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	3.10	$33,000	No	0.4420	Miscellaneous	Miscellaneous
530-2	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	3.86	$33,000	No	0.6163	Miscellaneous	Miscellaneous
530-3	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	6.44	$33,000	No	0.9992	Miscellaneous	Miscellaneous
530-4	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	11.78	$56,921	No	1.8971	Miscellaneous	Miscellaneous
531-1	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	2.67	$33,000	No	0.4544	Miscellaneous	Miscellaneous
531-2	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	3.83	$33,000	No	0.6406	Miscellaneous	Miscellaneous
531-3	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	6.38	$33,000	No	0.9987	Miscellaneous	Miscellaneous
531-4	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	13.03	$61,221	No	2.0594	Miscellaneous	Miscellaneous
532-1	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	1.78	$33,000	No	0.3921	Miscellaneous	Miscellaneous
532-2	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	2.38	$33,000	No	0.4786	Miscellaneous	Miscellaneous
532-3	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	4.35	$33,000	No	0.7941	Miscellaneous	Miscellaneous
532-4	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	10.04	$45,915	No	1.7650	Miscellaneous	Miscellaneous
540-1	CESAREAN DELIVERY	2.99	$33,000	No	0.5654	Obstetrics	Obstetrics
540-2	CESAREAN DELIVERY	3.91	$33,000	No	0.6863	Obstetrics	Obstetrics
540-3	CESAREAN DELIVERY	6.35	$33,000	No	0.9354	Obstetrics	Obstetrics
540-4	CESAREAN DELIVERY	10.54	$54,053	No	2.3718	Obstetrics	Obstetrics
541-1	VAGINAL DELIVERY W STERILIZATION &/OR D&C	2.12	$33,000	Yes	0.5628	Obstetrics	Obstetrics
541-2	VAGINAL DELIVERY W STERILIZATION &/OR D&C	2.49	$33,000	Yes	0.6075	Obstetrics	Obstetrics
541-3	VAGINAL DELIVERY W STERILIZATION &/OR D&C	4.92	$33,000	Yes	0.8660	Obstetrics	Obstetrics
541-4	VAGINAL DELIVERY W STERILIZATION &/OR D&C	8.39	$57,852	Yes	2.3515	Obstetrics	Obstetrics
542-1	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	2.16	$33,000	No	0.3695	Obstetrics	Obstetrics
542-2	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	2.96	$33,000	No	0.4647	Obstetrics	Obstetrics
542-3	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	6.15	$33,000	No	0.8571	Obstetrics	Obstetrics
542-4	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	9.94	$95,132	No	3.6194	Obstetrics	Obstetrics

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
544-1	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	1.37	$33,000	No	0.4585	Obstetrics	Obstetrics
544-2	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	2.01	$33,000	No	0.5897	Obstetrics	Obstetrics
544-3	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	4.08	$33,000	No	0.9821	Obstetrics	Obstetrics
544-4	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	9.15	$76,503	No	2.5061	Obstetrics	Obstetrics
545-1	ECTOPIC PREGNANCY PROCEDURE	1.64	$33,000	No	0.6988	Obstetrics	Obstetrics
545-2	ECTOPIC PREGNANCY PROCEDURE	1.91	$33,000	No	0.8147	Obstetrics	Obstetrics
545-3	ECTOPIC PREGNANCY PROCEDURE	2.66	$33,000	No	1.0539	Obstetrics	Obstetrics
545-4	ECTOPIC PREGNANCY PROCEDURE	5.76	$49,438	No	1.9944	Obstetrics	Obstetrics
546-1	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES	2.86	$33,000	No	0.5022	Obstetrics	Obstetrics
546-2	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES	4.55	$33,000	No	0.7207	Obstetrics	Obstetrics
546-3	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES	7.55	$33,000	No	1.3294	Obstetrics	Obstetrics
546-4	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES	14.46	$98,000	No	4.3377	Obstetrics	Obstetrics
560-1	VAGINAL DELIVERY	2.03	$33,000	Yes	0.3307	Obstetrics	Obstetrics
560-2	VAGINAL DELIVERY	2.38	$33,000	Yes	0.3855	Obstetrics	Obstetrics
560-3	VAGINAL DELIVERY	3.85	$33,000	Yes	0.5399	Obstetrics	Obstetrics
560-4	VAGINAL DELIVERY	9.35	$46,712	Yes	1.5061	Obstetrics	Obstetrics
561-1	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	2.11	$33,000	No	0.2510	Obstetrics	Obstetrics
561-2	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	2.58	$33,000	No	0.3907	Obstetrics	Obstetrics
561-3	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	3.93	$33,000	No	0.6071	Obstetrics	Obstetrics
561-4	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	6.88	$98,000	No	1.5616	Obstetrics	Obstetrics
563-1	THREATENED ABORTION	2.59	$33,000	No	0.2580	Obstetrics	Obstetrics
563-2	THREATENED ABORTION	3.92	$33,000	No	0.3376	Obstetrics	Obstetrics
563-3	THREATENED ABORTION	7.47	$33,000	No	0.5162	Obstetrics	Obstetrics
563-4	THREATENED ABORTION	7.20	$33,000	No	0.9651	Obstetrics	Obstetrics
564-1	ABORTION W/O D&C, ASPIRATION	1.38	$33,000	No	0.2880	Obstetrics	Obstetrics

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
	CURETTAGE OR HYSTEROTOMY						
564-2	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.71	$33,000	No	0.3462	Obstetrics	Obstetrics
564-3	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	2.77	$33,000	No	0.4901	Obstetrics	Obstetrics
564-4	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	8.09	$56,037	No	1.6676	Obstetrics	Obstetrics
565-1	FALSE LABOR	1.24	$33,000	Yes	0.1245	Obstetrics	Obstetrics
565-2	FALSE LABOR	1.86	$33,000	Yes	0.1781	Obstetrics	Obstetrics
565-3	FALSE LABOR	7.35	$33,000	Yes	0.2687	Obstetrics	Obstetrics
565-4	FALSE LABOR	8.09	$33,000	Yes	0.2985	Obstetrics	Obstetrics
566-1	OTHER ANTEPARTUM DIAGNOSES	2.12	$33,000	No	0.2442	Obstetrics	Obstetrics
566-2	OTHER ANTEPARTUM DIAGNOSES	2.94	$33,000	No	0.3252	Obstetrics	Obstetrics
566-3	OTHER ANTEPARTUM DIAGNOSES	5.44	$33,000	No	0.4790	Obstetrics	Obstetrics
566-4	OTHER ANTEPARTUM DIAGNOSES	8.43	$49,133	No	1.4726	Obstetrics	Obstetrics
580-1	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE	1.44	$33,000	No	0.2397	Neonate	Neonate
580-2	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE	1.60	$33,000	No	0.3209	Neonate	Neonate
580-3	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE	1.82	$33,000	No	0.5010	Neonate	Neonate
580-4	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE	1.65	$33,000	No	0.8511	Neonate	Neonate
581-1	NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE	1.25	$33,000	No	0.0981	Neonate	Neonate
581-2	NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE	1.29	$33,000	No	0.1476	Neonate	Neonate
581-3	NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE	1.26	$33,000	No	0.2362	Neonate	Neonate
581-4	NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE	1.36	$33,000	No	0.4408	Neonate	Neonate
583-1	NEONATE W ECMO	20.70	$33,000	No	9.9740	Neonate	Neonate
583-2	NEONATE W ECMO	23.00	$98,000	No	15.7495	Neonate	Neonate
583-3	NEONATE W ECMO	30.78	$98,000	No	17.3245	Neonate	Neonate
583-4	NEONATE W ECMO	48.87	$98,000	No	24.0893	Neonate	Neonate
588-1	NEONATE BWT <1500G W MAJOR PROCEDURE	44.42	$33,000	No	4.8409	Neonate	Neonate
588-2	NEONATE BWT <1500G W MAJOR PROCEDURE	49.36	$98,000	No	7.0034	Neonate	Neonate
588-3	NEONATE BWT <1500G W MAJOR PROCEDURE	77.14	$98,000	No	14.2903	Neonate	Neonate
588-4	NEONATE BWT <1500G W MAJOR PROCEDURE	102.07	$98,000	No	21.6659	Neonate	Neonate

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
589-1	NEONATE BWT <500G	58.43	$98,000	No	11.5467	Neonate	Neonate
589-2	NEONATE BWT <500G	50.42	$98,000	No	10.4971	Neonate	Neonate
589-3	NEONATE BWT <500G	30.36	$98,000	No	9.5429	Neonate	Neonate
589-4	NEONATE BWT <500G	2.66	$47,938	No	0.4453	Neonate	Neonate
591-1	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE	2.11	$33,000	No	0.1574	Neonate	Neonate
591-2	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE	37.10	$98,000	No	5.5672	Neonate	Neonate
591-3	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE	50.61	$98,000	No	8.8282	Neonate	Neonate
591-4	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE	72.21	$98,000	No	13.2286	Neonate	Neonate
593-1	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE	19.28	$58,745	No	1.5109	Neonate	Neonate
593-2	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE	48.51	$98,000	No	5.1913	Neonate	Neonate
593-3	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE	59.66	$98,000	No	8.2800	Neonate	Neonate
593-4	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE	71.43	$98,000	No	12.2454	Neonate	Neonate
602-1	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	25.13	$79,263	No	2.9634	Neonate	Neonate
602-2	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	44.03	$98,000	No	5.8706	Neonate	Neonate
602-3	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	53.24	$98,000	No	7.7592	Neonate	Neonate
602-4	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	63.07	$98,000	No	10.4732	Neonate	Neonate
603-1	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION	22.34	$65,742	No	1.7223	Neonate	Neonate
603-2	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION	36.20	$98,000	No	4.2525	Neonate	Neonate
603-3	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION	48.44	$98,000	No	6.5587	Neonate	Neonate
603-4	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION	53.96	$98,000	No	7.0749	Neonate	Neonate
607-1	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	25.09	$75,529	No	2.7503	Neonate	Neonate
607-2	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	35.82	$98,000	No	4.7485	Neonate	Neonate
607-3	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	43.42	$98,000	No	6.1883	Neonate	Neonate
607-4	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	49.58	$98,000	No	7.9508	Neonate	Neonate
608-1	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION	19.81	$54,084	No	2.1292	Neonate	Neonate
608-2	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION	30.04	$81,009	No	3.6047	Neonate	Neonate

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
608-3	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION	38.47	$98,000	No	5.2684	Neonate	Neonate
608-4	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION	44.15	$98,000	No	6.0424	Neonate	Neonate
609-1	NEONATE BWT 1500-2499G W MAJOR PROCEDURE	19.34	$69,222	No	2.7332	Neonate	Neonate
609-2	NEONATE BWT 1500-2499G W MAJOR PROCEDURE	22.11	$94,281	No	3.8628	Neonate	Neonate
609-3	NEONATE BWT 1500-2499G W MAJOR PROCEDURE	38.04	$98,000	No	6.5635	Neonate	Neonate
609-4	NEONATE BWT 1500-2499G W MAJOR PROCEDURE	62.67	$98,000	No	11.9134	Neonate	Neonate
611-1	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY	13.14	$40,099	No	1.1779	Neonate	Neonate
611-2	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY	21.24	$53,823	No	2.5158	Neonate	Neonate
611-3	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY	31.33	$87,450	No	4.0556	Neonate	Neonate
611-4	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY	36.15	$98,000	No	5.2441	Neonate	Neonate
612-1	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND	17.57	$38,869	No	2.1879	Neonate	Neonate
612-2	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND	24.42	$57,571	No	3.2223	Neonate	Neonate
612-3	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND	32.49	$96,592	No	4.6803	Neonate	Neonate
612-4	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND	38.34	$98,000	No	6.2296	Neonate	Neonate
613-1	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION	14.39	$43,683	No	1.6593	Neonate	Neonate
613-2	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION	21.54	$68,285	No	2.6830	Neonate	Neonate
613-3	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION	28.54	$89,555	No	3.7601	Neonate	Neonate
613-4	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION	33.39	$98,000	No	4.8827	Neonate	Neonate
614-1	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION	11.24	$33,000	No	0.9240	Neonate	Neonate
614-2	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION	20.09	$44,537	No	2.2768	Neonate	Neonate
614-3	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION	28.53	$88,327	No	3.6402	Neonate	Neonate
614-4	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION	36.41	$98,000	No	5.0802	Neonate	Neonate
621-1	NEONATE BWT 2000-2499G W MAJOR ANOMALY	8.21	$33,000	No	0.6081	Neonate	Neonate
621-2	NEONATE BWT 2000-2499G W MAJOR ANOMALY	13.98	$42,779	No	1.5378	Neonate	Neonate
621-3	NEONATE BWT 2000-2499G W MAJOR ANOMALY	21.25	$73,614	No	2.7205	Neonate	Neonate

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
621-4	NEONATE BWT 2000-2499G W MAJOR ANOMALY	24.17	$98,000	No	3.8100	Neonate	Neonate
622-1	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND	11.19	$33,000	No	1.3665	Neonate	Neonate
622-2	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND	15.14	$37,924	No	2.0912	Neonate	Neonate
622-3	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND	19.78	$56,625	No	2.9736	Neonate	Neonate
622-4	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND	22.85	$98,000	No	4.7202	Neonate	Neonate
623-1	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION	9.25	$33,000	No	0.9933	Neonate	Neonate
623-2	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION	13.99	$45,559	No	1.6799	Neonate	Neonate
623-3	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION	18.72	$64,130	No	2.5086	Neonate	Neonate
623-4	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION	27.38	$98,000	No	3.8931	Neonate	Neonate
625-1	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION	11.58	$33,000	No	1.1469	Neonate	Neonate
625-2	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION	16.21	$43,307	No	1.8626	Neonate	Neonate
625-3	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION	19.25	$52,331	No	2.3297	Neonate	Neonate
625-4	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION	20.15	$81,179	No	2.9193	Neonate	Neonate
626-1	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	2.80	$33,000	No	0.1386	Normal newborn	Normal newborn
626-2	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	4.57	$33,000	No	0.2586	Normal newborn	Normal newborn
626-3	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	8.65	$33,000	No	0.7679	Normal newborn	Normal newborn
626-4	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	18.39	$41,499	No	2.2819	Normal newborn	Normal newborn
630-1	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE	4.86	$46,706	No	2.0467	Neonate	Neonate
630-2	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE	9.40	$84,914	No	3.2885	Neonate	Neonate
630-3	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE	14.48	$98,000	No	5.2249	Neonate	Neonate
630-4	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE	39.12	$98,000	No	11.2071	Neonate	Neonate
631-1	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE	3.36	$33,000	No	0.9217	Neonate	Neonate
631-2	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE	8.87	$98,000	No	1.6766	Neonate	Neonate

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
631-3	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE	22.80	$98,000	No	3.7480	Neonate	Neonate
631-4	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE	51.12	$98,000	No	9.6324	Neonate	Neonate
633-1	NEONATE BIRTHWT >2499G W MAJOR ANOMALY	2.97	$33,000	No	0.1971	Neonate	Neonate
633-2	NEONATE BIRTHWT >2499G W MAJOR ANOMALY	6.51	$33,000	No	0.5798	Neonate	Neonate
633-3	NEONATE BIRTHWT >2499G W MAJOR ANOMALY	12.26	$55,002	No	1.3891	Neonate	Neonate
633-4	NEONATE BIRTHWT >2499G W MAJOR ANOMALY	23.82	$98,000	No	3.9727	Neonate	Neonate
634-1	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	4.66	$33,000	No	0.4885	Neonate	Neonate
634-2	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	7.49	$33,000	No	0.9445	Neonate	Neonate
634-3	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	12.61	$36,754	No	2.0176	Neonate	Neonate
634-4	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	22.33	$98,000	No	4.6933	Neonate	Neonate
636-1	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION	5.58	$33,000	No	0.5581	Neonate	Neonate
636-2	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION	7.80	$33,000	No	0.8839	Neonate	Neonate
636-3	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION	11.64	$51,363	No	1.5558	Neonate	Neonate
636-4	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION	18.97	$98,000	No	3.0612	Neonate	Neonate
639-1	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION	4.41	$33,000	No	0.3286	Neonate	Neonate
639-2	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION	7.04	$48,610	No	0.6622	Neonate	Neonate
639-3	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION	9.99	$54,346	No	1.1809	Neonate	Neonate
639-4	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION	16.53	$91,288	No	2.7285	Neonate	Neonate
640-1	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	2.10	$33,000	Yes	0.1012	Normal newborn	Normal newborn
640-2	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	2.45	$33,000	Yes	0.1352	Normal newborn	Normal newborn
640-3	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	3.77	$33,000	Yes	0.2863	Normal newborn	Normal newborn
640-4	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	12.06	$39,863	Yes	1.4726	Normal newborn	Normal newborn
650-1	SPLENECTOMY	3.48	$33,000	No	1.2985	Miscellaneous	Miscellaneous
650-2	SPLENECTOMY	5.37	$40,088	No	1.7964	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
650-3	SPLENECTOMY	8.48	$64,554	No	2.5202	Miscellaneous	Miscellaneous
650-4	SPLENECTOMY	15.64	$98,000	No	5.0825	Miscellaneous	Miscellaneous
651-1	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS	3.31	$33,000	No	0.9233	Miscellaneous	Miscellaneous
651-2	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS	4.72	$33,000	No	1.3695	Miscellaneous	Miscellaneous
651-3	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS	9.63	$56,577	No	2.1005	Miscellaneous	Miscellaneous
651-4	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS	24.26	$98,000	No	5.9540	Miscellaneous	Miscellaneous
660-1	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	3.06	$33,000	No	0.5398	Miscellaneous	Miscellaneous
660-2	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	4.09	$33,000	No	0.7218	Miscellaneous	Miscellaneous
660-3	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	6.49	$52,055	No	1.1819	Miscellaneous	Miscellaneous
660-4	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	14.35	$98,000	No	3.0180	Miscellaneous	Miscellaneous
661-1	COAGULATION & PLATELET DISORDERS	2.76	$33,000	No	0.6473	Miscellaneous	Miscellaneous
661-2	COAGULATION & PLATELET DISORDERS	3.76	$33,000	No	0.8098	Miscellaneous	Miscellaneous
661-3	COAGULATION & PLATELET DISORDERS	5.66	$33,000	No	1.2432	Miscellaneous	Miscellaneous
661-4	COAGULATION & PLATELET DISORDERS	12.65	$97,035	No	2.7856	Miscellaneous	Miscellaneous
662-1	SICKLE CELL ANEMIA CRISIS	4.12	$33,000	No	0.5044	Miscellaneous	Miscellaneous
662-2	SICKLE CELL ANEMIA CRISIS	5.39	$33,000	No	0.7003	Miscellaneous	Miscellaneous
662-3	SICKLE CELL ANEMIA CRISIS	7.85	$33,000	No	1.0777	Miscellaneous	Miscellaneous
662-4	SICKLE CELL ANEMIA CRISIS	13.03	$68,923	No	2.3937	Miscellaneous	Miscellaneous
663-1	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	2.33	$33,000	No	0.4474	Miscellaneous	Miscellaneous
663-2	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	3.01	$33,000	No	0.5958	Miscellaneous	Miscellaneous
663-3	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	4.51	$33,000	No	0.8512	Miscellaneous	Miscellaneous
663-4	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	9.01	$49,527	No	1.6106	Miscellaneous	Miscellaneous
680-1	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	4.09	$33,031	No	1.3701	Miscellaneous	Miscellaneous
680-2	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	6.34	$46,102	No	1.8600	Miscellaneous	Miscellaneous
680-3	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	11.85	$83,034	No	3.2002	Miscellaneous	Miscellaneous
680-4	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER	24.56	$98,000	No	6.6288	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
	NEOPLASMS						
681-1	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	2.68	$33,000	No	0.9799	Miscellaneous	Miscellaneous
681-2	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	5.07	$33,307	No	1.3647	Miscellaneous	Miscellaneous
681-3	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	11.12	$76,878	No	2.4596	Miscellaneous	Miscellaneous
681-4	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	25.11	$98,000	No	5.9169	Miscellaneous	Miscellaneous
690-1	ACUTE LEUKEMIA	4.95	$33,000	No	0.7040	Miscellaneous	Miscellaneous
690-2	ACUTE LEUKEMIA	7.41	$33,000	No	1.1868	Miscellaneous	Miscellaneous
690-3	ACUTE LEUKEMIA	14.62	$98,000	No	2.3550	Miscellaneous	Miscellaneous
690-4	ACUTE LEUKEMIA	24.86	$98,000	No	5.2503	Miscellaneous	Miscellaneous
691-1	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	3.89	$33,000	No	0.7076	Miscellaneous	Miscellaneous
691-2	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	5.40	$33,000	No	0.9840	Miscellaneous	Miscellaneous
691-3	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	8.62	$57,095	No	1.5476	Miscellaneous	Miscellaneous
691-4	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	15.86	$98,000	No	3.1411	Miscellaneous	Miscellaneous
692-1	RADIOTHERAPY	3.90	$33,000	No	0.6075	Miscellaneous	Miscellaneous
692-2	RADIOTHERAPY	4.83	$37,152	No	1.2583	Miscellaneous	Miscellaneous
692-3	RADIOTHERAPY	8.69	$54,687	No	1.7422	Miscellaneous	Miscellaneous
692-4	RADIOTHERAPY	15.81	$98,000	No	2.9316	Miscellaneous	Miscellaneous
693-1	CHEMOTHERAPY	2.82	$33,000	No	0.6251	Miscellaneous	Miscellaneous
693-2	CHEMOTHERAPY	3.68	$33,000	No	0.7880	Miscellaneous	Miscellaneous
693-3	CHEMOTHERAPY	7.85	$43,989	No	1.3636	Miscellaneous	Miscellaneous
693-4	CHEMOTHERAPY	24.10	$98,000	No	4.9083	Miscellaneous	Miscellaneous
694-1	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	3.05	$33,000	No	0.4842	Miscellaneous	Miscellaneous
694-2	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	4.04	$33,000	No	0.6831	Miscellaneous	Miscellaneous
694-3	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	6.75	$33,000	No	1.1114	Miscellaneous	Miscellaneous
694-4	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	11.65	$64,705	No	2.1000	Miscellaneous	Miscellaneous
710-1	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE	5.11	$33,000	No	1.0635	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
710-2	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE	6.80	$33,338	No	1.5963	Miscellaneous	Miscellaneous
710-3	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE	11.12	$61,014	No	2.5572	Miscellaneous	Miscellaneous
710-4	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE	18.20	$98,000	No	4.9381	Miscellaneous	Miscellaneous
711-1	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE	4.71	$33,000	No	1.0079	Miscellaneous	Miscellaneous
711-2	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE	6.93	$43,625	No	1.4143	Miscellaneous	Miscellaneous
711-3	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE	11.31	$82,814	No	2.3598	Miscellaneous	Miscellaneous
711-4	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE	20.88	$98,000	No	5.0574	Miscellaneous	Miscellaneous
720-1	SEPTICEMIA & DISSEMINATED INFECTIONS	3.54	$33,000	No	0.5431	Miscellaneous	Miscellaneous
720-2	SEPTICEMIA & DISSEMINATED INFECTIONS	4.45	$33,000	No	0.7612	Miscellaneous	Miscellaneous
720-3	SEPTICEMIA & DISSEMINATED INFECTIONS	6.33	$34,506	No	1.1532	Miscellaneous	Miscellaneous
720-4	SEPTICEMIA & DISSEMINATED INFECTIONS	10.04	$98,000	No	2.1705	Miscellaneous	Miscellaneous
721-1	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	3.68	$33,000	No	0.5286	Miscellaneous	Miscellaneous
721-2	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	4.70	$33,000	No	0.7208	Miscellaneous	Miscellaneous
721-3	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	7.05	$48,013	No	1.1618	Miscellaneous	Miscellaneous
721-4	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	11.54	$86,244	No	2.2025	Miscellaneous	Miscellaneous
722-1	FEVER	2.30	$33,000	No	0.3423	Miscellaneous	Miscellaneous
722-2	FEVER	3.03	$33,000	No	0.5223	Miscellaneous	Miscellaneous
722-3	FEVER	4.30	$33,000	No	0.7629	Miscellaneous	Miscellaneous
722-4	FEVER	7.40	$33,000	No	1.3141	Miscellaneous	Miscellaneous
723-1	VIRAL ILLNESS	2.16	$33,000	No	0.3193	Miscellaneous	Miscellaneous
723-2	VIRAL ILLNESS	2.80	$33,000	No	0.4737	Miscellaneous	Miscellaneous
723-3	VIRAL ILLNESS	4.70	$33,000	No	0.7794	Miscellaneous	Miscellaneous
723-4	VIRAL ILLNESS	13.17	$74,873	No	2.4233	Miscellaneous	Miscellaneous
724-1	OTHER INFECTIOUS & PARASITIC DISEASES	4.01	$33,000	No	0.5512	Miscellaneous	Miscellaneous
724-2	OTHER INFECTIOUS & PARASITIC DISEASES	4.77	$33,000	No	0.7130	Miscellaneous	Miscellaneous
724-3	OTHER INFECTIOUS & PARASITIC DISEASES	6.80	$34,284	No	1.1401	Miscellaneous	Miscellaneous
724-4	OTHER INFECTIOUS & PARASITIC DISEASES	13.37	$44,677	No	2.4698	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
740-1	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	6.79	$33,724	No	1.0899	Mental health	Mental health
740-2	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	12.84	$35,801	No	1.3904	Mental health	Mental health
740-3	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	20.34	$63,365	No	2.4355	Mental health	Mental health
740-4	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	24.22	$93,346	No	3.7755	Mental health	Mental health
750-1	SCHIZOPHRENIA	10.82	$33,935	No	0.5713	Mental health	Mental health
750-2	SCHIZOPHRENIA	11.80	$42,770	No	0.6699	Mental health	Mental health
750-3	SCHIZOPHRENIA	15.39	$59,000	No	0.9201	Mental health	Mental health
750-4	SCHIZOPHRENIA	28.48	$51,423	No	1.9282	Mental health	Mental health
751-1	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	5.29	$33,000	No	0.3571	Mental health	Mental health
751-2	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	7.25	$33,000	No	0.5018	Mental health	Mental health
751-3	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	10.55	$33,000	No	0.8096	Mental health	Mental health
751-4	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	20.29	$39,404	No	1.5922	Mental health	Mental health
752-1	DISORDERS OF PERSONALITY & IMPULSE CONTROL	5.04	$33,000	No	0.3398	Mental health	Mental health
752-2	DISORDERS OF PERSONALITY & IMPULSE CONTROL	6.59	$33,000	No	0.4497	Mental health	Mental health
752-3	DISORDERS OF PERSONALITY & IMPULSE CONTROL	14.73	$33,000	No	0.9061	Mental health	Mental health
752-4	DISORDERS OF PERSONALITY & IMPULSE CONTROL	73.00	$98,000	No	1.4934	Mental health	Mental health
753-1	BIPOLAR DISORDERS	6.02	$33,000	No	0.4000	Mental health	Mental health
753-2	BIPOLAR DISORDERS	8.09	$33,000	No	0.5365	Mental health	Mental health
753-3	BIPOLAR DISORDERS	12.05	$33,000	No	0.8265	Mental health	Mental health
753-4	BIPOLAR DISORDERS	19.48	$37,025	No	1.4926	Mental health	Mental health
754-1	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	4.24	$33,000	No	0.2943	Mental health	Mental health
754-2	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	5.59	$33,000	No	0.3998	Mental health	Mental health
754-3	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	7.27	$33,000	No	0.5676	Mental health	Mental health
754-4	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	16.65	$33,000	No	1.1553	Mental health	Mental health
755-1	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	3.88	$33,000	No	0.2738	Mental health	Mental health
755-2	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	6.23	$33,000	No	0.4363	Mental health	Mental health
755-3	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	9.00	$33,000	No	0.6225	Mental health	Mental health

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
755-4	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	8.13	$33,000	No	0.8767	Mental health	Mental health
756-1	ACUTE ANXIETY & DELIRIUM STATES	3.31	$33,000	No	0.4060	Mental health	Mental health
756-2	ACUTE ANXIETY & DELIRIUM STATES	3.81	$33,000	No	0.5308	Mental health	Mental health
756-3	ACUTE ANXIETY & DELIRIUM STATES	4.57	$33,000	No	0.6065	Mental health	Mental health
756-4	ACUTE ANXIETY & DELIRIUM STATES	9.43	$38,541	No	1.3981	Mental health	Mental health
757-1	ORGANIC MENTAL HEALTH DISTURBANCES	8.73	$33,000	No	0.5861	Mental health	Mental health
757-2	ORGANIC MENTAL HEALTH DISTURBANCES	9.34	$33,000	No	0.7234	Mental health	Mental health
757-3	ORGANIC MENTAL HEALTH DISTURBANCES	10.88	$91,828	No	0.8953	Mental health	Mental health
757-4	ORGANIC MENTAL HEALTH DISTURBANCES	16.41	$44,635	No	1.3798	Mental health	Mental health
758-1	CHILDHOOD BEHAVIORAL DISORDERS	6.95	$33,000	No	0.3873	Mental health	Mental health
758-2	CHILDHOOD BEHAVIORAL DISORDERS	9.81	$33,000	No	0.5129	Mental health	Mental health
758-3	CHILDHOOD BEHAVIORAL DISORDERS	12.26	$33,000	No	0.6541	Mental health	Mental health
758-4	CHILDHOOD BEHAVIORAL DISORDERS	43.00	$80,288	No	1.1332	Mental health	Mental health
759-1	EATING DISORDERS	19.91	$33,000	No	0.6560	Mental health	Mental health
759-2	EATING DISORDERS	12.97	$33,000	No	0.6961	Mental health	Mental health
759-3	EATING DISORDERS	14.03	$33,000	No	1.0053	Mental health	Mental health
759-4	EATING DISORDERS	23.03	$58,468	No	1.6605	Mental health	Mental health
760-1	OTHER MENTAL HEALTH DISORDERS	7.49	$33,000	No	0.4839	Mental health	Mental health
760-2	OTHER MENTAL HEALTH DISORDERS	7.66	$33,000	No	0.6172	Mental health	Mental health
760-3	OTHER MENTAL HEALTH DISORDERS	9.12	$33,000	No	0.7573	Mental health	Mental health
760-4	OTHER MENTAL HEALTH DISORDERS	12.04	$33,907	No	1.4133	Mental health	Mental health
770-1	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	2.54	$33,000	No	0.2239	Miscellaneous	Miscellaneous
770-2	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	2.48	$33,000	No	0.2622	Miscellaneous	Miscellaneous
770-3	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	3.32	$33,000	No	0.5475	Miscellaneous	Miscellaneous
770-4	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	7.95	$50,490	No	1.6842	Miscellaneous	Miscellaneous
772-1	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY	14.35	$33,000	No	0.5441	Miscellaneous	Miscellaneous
772-2	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY	15.52	$33,000	No	0.6915	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
772-3	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY	12.90	$33,000	No	0.7008	Miscellaneous	Miscellaneous
772-4	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY	23.85	$72,950	No	2.4529	Miscellaneous	Miscellaneous
773-1	OPIOID ABUSE & DEPENDENCE	3.38	$33,000	No	0.2662	Miscellaneous	Miscellaneous
773-2	OPIOID ABUSE & DEPENDENCE	4.15	$33,000	No	0.3466	Miscellaneous	Miscellaneous
773-3	OPIOID ABUSE & DEPENDENCE	5.08	$33,000	No	0.5963	Miscellaneous	Miscellaneous
773-4	OPIOID ABUSE & DEPENDENCE	9.92	$46,941	No	1.8605	Miscellaneous	Miscellaneous
774-1	COCAINE ABUSE & DEPENDENCE	3.65	$33,000	No	0.3040	Miscellaneous	Miscellaneous
774-2	COCAINE ABUSE & DEPENDENCE	4.13	$33,000	No	0.3627	Miscellaneous	Miscellaneous
774-3	COCAINE ABUSE & DEPENDENCE	4.79	$33,000	No	0.6447	Miscellaneous	Miscellaneous
774-4	COCAINE ABUSE & DEPENDENCE	14.25	$78,479	No	2.4682	Miscellaneous	Miscellaneous
775-1	ALCOHOL ABUSE & DEPENDENCE	3.24	$33,000	No	0.3312	Miscellaneous	Miscellaneous
775-2	ALCOHOL ABUSE & DEPENDENCE	3.78	$33,000	No	0.4638	Miscellaneous	Miscellaneous
775-3	ALCOHOL ABUSE & DEPENDENCE	5.72	$40,654	No	0.8596	Miscellaneous	Miscellaneous
775-4	ALCOHOL ABUSE & DEPENDENCE	12.63	$98,000	No	2.4910	Miscellaneous	Miscellaneous
776-1	OTHER DRUG ABUSE & DEPENDENCE	3.89	$33,000	No	0.3157	Miscellaneous	Miscellaneous
776-2	OTHER DRUG ABUSE & DEPENDENCE	3.98	$33,000	No	0.4546	Miscellaneous	Miscellaneous
776-3	OTHER DRUG ABUSE & DEPENDENCE	4.97	$33,000	No	0.7886	Miscellaneous	Miscellaneous
776-4	OTHER DRUG ABUSE & DEPENDENCE	9.34	$42,327	No	1.6112	Miscellaneous	Miscellaneous
791-1	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT	3.15	$33,000	No	0.8635	Miscellaneous	Miscellaneous
791-2	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT	5.16	$49,582	No	1.2676	Miscellaneous	Miscellaneous
791-3	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT	9.90	$42,546	No	2.1979	Miscellaneous	Miscellaneous
791-4	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT	20.09	$98,000	No	4.9311	Miscellaneous	Miscellaneous
811-1	ALLERGIC REACTIONS	1.52	$33,000	No	0.2707	Miscellaneous	Miscellaneous
811-2	ALLERGIC REACTIONS	2.02	$33,000	No	0.3854	Miscellaneous	Miscellaneous
811-3	ALLERGIC REACTIONS	3.90	$33,000	No	0.8277	Miscellaneous	Miscellaneous
811-4	ALLERGIC REACTIONS	9.14	$59,901	No	2.2176	Miscellaneous	Miscellaneous
812-1	POISONING OF MEDICINAL AGENTS	1.65	$33,000	No	0.3468	Miscellaneous	Miscellaneous
812-2	POISONING OF MEDICINAL AGENTS	2.25	$33,000	No	0.4331	Miscellaneous	Miscellaneous
812-3	POISONING OF MEDICINAL AGENTS	3.47	$33,000	No	0.7708	Miscellaneous	Miscellaneous
812-4	POISONING OF MEDICINAL AGENTS	6.94	$38,755	No	1.7418	Miscellaneous	Miscellaneous
813-1	OTHER COMPLICATIONS OF TREATMENT	2.61	$33,000	No	0.4393	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
813-2	OTHER COMPLICATIONS OF TREATMENT	3.44	$33,000	No	0.6056	Miscellaneous	Miscellaneous
813-3	OTHER COMPLICATIONS OF TREATMENT	5.94	$33,000	No	0.9631	Miscellaneous	Miscellaneous
813-4	OTHER COMPLICATIONS OF TREATMENT	13.45	$66,734	No	1.9959	Miscellaneous	Miscellaneous
815-1	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	1.69	$33,000	No	0.4210	Miscellaneous	Miscellaneous
815-2	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	2.77	$33,000	No	0.5011	Miscellaneous	Miscellaneous
815-3	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	4.57	$33,000	No	0.8128	Miscellaneous	Miscellaneous
815-4	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	8.80	$63,963	No	2.2714	Miscellaneous	Miscellaneous
816-1	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	1.73	$33,000	No	0.4162	Miscellaneous	Miscellaneous
816-2	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	2.41	$33,000	No	0.4914	Miscellaneous	Miscellaneous
816-3	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	3.47	$33,000	No	0.7864	Miscellaneous	Miscellaneous
816-4	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	7.36	$79,015	No	1.8134	Miscellaneous	Miscellaneous
841-1	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	22.00	$98,000	No	3.1148	Miscellaneous	Miscellaneous
841-2	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	9.67	$50,880	No	3.4263	Miscellaneous	Miscellaneous
841-3	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	26.00	$98,000	No	6.4067	Miscellaneous	Miscellaneous
841-4	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	40.69	$98,000	No	15.9153	Miscellaneous	Miscellaneous
842-1	FULL THICKNESS BURNS W SKIN GRAFT	7.51	$33,000	No	1.4151	Miscellaneous	Miscellaneous
842-2	FULL THICKNESS BURNS W SKIN GRAFT	10.72	$33,000	No	2.1416	Miscellaneous	Miscellaneous
842-3	FULL THICKNESS BURNS W SKIN GRAFT	17.35	$41,925	No	3.8718	Miscellaneous	Miscellaneous
842-4	FULL THICKNESS BURNS W SKIN GRAFT	30.11	$98,000	No	9.5053	Miscellaneous	Miscellaneous
843-1	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	3.39	$33,000	No	0.4751	Miscellaneous	Miscellaneous
843-2	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	4.87	$33,000	No	0.6660	Miscellaneous	Miscellaneous
843-3	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	7.13	$34,060	No	1.1618	Miscellaneous	Miscellaneous
843-4	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	11.14	$98,000	No	3.2620	Miscellaneous	Miscellaneous
844-1	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT	3.11	$33,000	No	0.4336	Miscellaneous	Miscellaneous
844-2	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT	4.97	$33,000	No	0.6964	Miscellaneous	Miscellaneous
844-3	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT	7.43	$35,244	No	1.2192	Miscellaneous	Miscellaneous
844-4	PARTIAL THICKNESS BURNS W OR W/O	17.82	$98,000	No	4.8020	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
	SKIN GRAFT						
850-1	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE	2.67	$37,381	No	1.1756	Rehab	Rehab
850-2	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE	5.57	$36,246	No	1.4064	Rehab	Rehab
850-3	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE	16.19	$45,703	No	2.4869	Rehab	Rehab
850-4	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE	31.49	$98,000	No	4.6520	Rehab	Rehab
860-1	REHABILITATION	9.33	$33,000	No	0.7226	Rehab	Rehab
860-2	REHABILITATION	11.47	$33,000	No	0.9854	Rehab	Rehab
860-3	REHABILITATION	14.76	$35,425	No	1.3879	Rehab	Rehab
860-4	REHABILITATION	17.95	$39,250	No	1.7876	Rehab	Rehab
861-1	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	2.54	$33,000	No	0.2858	Miscellaneous	Miscellaneous
861-2	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	3.40	$33,000	No	0.5246	Miscellaneous	Miscellaneous
861-3	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	4.98	$33,000	No	0.7657	Miscellaneous	Miscellaneous
861-4	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	9.17	$42,593	No	1.4497	Miscellaneous	Miscellaneous
862-1	OTHER AFTERCARE & CONVALESCENCE	6.99	$33,000	No	0.2895	Miscellaneous	Miscellaneous
862-2	OTHER AFTERCARE & CONVALESCENCE	11.23	$33,000	No	0.5851	Miscellaneous	Miscellaneous
862-3	OTHER AFTERCARE & CONVALESCENCE	13.58	$33,000	No	0.7865	Miscellaneous	Miscellaneous
862-4	OTHER AFTERCARE & CONVALESCENCE	18.72	$47,882	No	1.1351	Miscellaneous	Miscellaneous
863-1	NEONATAL AFTERCARE	8.53	$33,000	No	0.5959	Neonate	Neonate
863-2	NEONATAL AFTERCARE	17.58	$33,000	No	1.6126	Neonate	Neonate
863-3	NEONATAL AFTERCARE	27.72	$57,670	No	3.0507	Neonate	Neonate
863-4	NEONATAL AFTERCARE	46.43	$98,000	No	6.1445	Neonate	Neonate
890-1	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS	1.67	$33,000	No	0.7051	Miscellaneous	Miscellaneous
890-2	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS	6.92	$33,000	No	1.0224	Miscellaneous	Miscellaneous
890-3	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS	9.21	$60,353	No	1.4770	Miscellaneous	Miscellaneous
890-4	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS	15.15	$89,406	No	3.0013	Miscellaneous	Miscellaneous
892-1	HIV W MAJOR HIV RELATED CONDITION	5.88	$33,000	No	0.5646	Miscellaneous	Miscellaneous
892-2	HIV W MAJOR HIV RELATED CONDITION	4.88	$33,000	No	0.7762	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
892-3	HIV W MAJOR HIV RELATED CONDITION	6.69	$33,000	No	1.0877	Miscellaneous	Miscellaneous
892-4	HIV W MAJOR HIV RELATED CONDITION	11.53	$59,340	No	1.9374	Miscellaneous	Miscellaneous
893-1	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS	4.99	$33,000	No	0.7762	Miscellaneous	Miscellaneous
893-2	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS	4.96	$33,000	No	0.8218	Miscellaneous	Miscellaneous
893-3	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS	7.99	$33,000	No	1.2806	Miscellaneous	Miscellaneous
893-4	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS	14.22	$65,810	No	2.4296	Miscellaneous	Miscellaneous
894-1	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND	3.41	$33,000	No	0.5218	Miscellaneous	Miscellaneous
894-2	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND	3.94	$33,000	No	0.6496	Miscellaneous	Miscellaneous
894-3	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND	6.27	$33,000	No	0.9773	Miscellaneous	Miscellaneous
894-4	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND	11.22	$56,504	No	1.9427	Miscellaneous	Miscellaneous
910-1	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	11.00	$68,614	No	2.8785	Miscellaneous	Miscellaneous
910-2	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	7.75	$74,246	No	3.1984	Miscellaneous	Miscellaneous
910-3	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	10.57	$98,000	No	4.1627	Miscellaneous	Miscellaneous
910-4	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	18.31	$98,000	No	7.2114	Miscellaneous	Miscellaneous
911-1	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA	5.12	$33,000	No	1.5159	Miscellaneous	Miscellaneous
911-2	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA	6.20	$46,871	No	2.0188	Miscellaneous	Miscellaneous
911-3	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA	7.96	$68,352	No	2.6724	Miscellaneous	Miscellaneous
911-4	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA	16.88	$98,000	No	5.8038	Miscellaneous	Miscellaneous
912-1	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	5.59	$60,528	No	2.0950	Miscellaneous	Miscellaneous
912-2	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	6.08	$65,041	No	2.2758	Miscellaneous	Miscellaneous
912-3	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	9.86	$94,482	No	3.6409	Miscellaneous	Miscellaneous
912-4	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	17.82	$98,000	No	6.8884	Miscellaneous	Miscellaneous

SECTION 4 BILLING CODES

APR-DRGS AND RELATIVE WEIGHTS

APR-DRG	APR-DRG Description	National ALOS	Outlier Threshold	Same Day & One Day Exempt	HSRV Relative Weight	Medicaid Care Category	
						Pediatric	Adult
930-1	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE	3.22	$33,000	No	0.7825	Miscellaneous	Miscellaneous
930-2	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE	3.71	$33,000	No	0.9593	Miscellaneous	Miscellaneous
930-3	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE	5.97	$40,617	No	1.5857	Miscellaneous	Miscellaneous
930-4	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE	11.27	$98,000	No	3.3896	Miscellaneous	Miscellaneous
950-1	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.62	$50,938	No	1.3229	Miscellaneous	Miscellaneous
950-2	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	6.23	$53,369	No	2.0029	Miscellaneous	Miscellaneous
950-3	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	11.66	$81,500	No	3.1827	Miscellaneous	Miscellaneous
950-4	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	22.61	$98,000	No	6.0092	Miscellaneous	Miscellaneous
951-1	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.30	$33,000	No	0.9755	Miscellaneous	Miscellaneous
951-2	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	5.17	$35,542	No	1.4319	Miscellaneous	Miscellaneous
951-3	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	10.02	$65,949	No	2.4054	Miscellaneous	Miscellaneous
951-4	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	19.74	$98,000	No	4.6875	Miscellaneous	Miscellaneous
952-1	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.75	$33,000	No	0.7736	Miscellaneous	Miscellaneous
952-2	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	5.04	$33,000	No	1.1590	Miscellaneous	Miscellaneous
952-3	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	9.69	$54,893	No	2.0368	Miscellaneous	Miscellaneous
952-4	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	18.95	$85,849	No	3.9176	Miscellaneous	Miscellaneous
955-0	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	-				Error DRG	Error DRG
956-0	UNGROUPABLE	-				Error DRG	Error DRG

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

OUTPATIENT HOSPITAL SURGERIES CPT CODES

For the following CPT codes for outpatient hospital surgeries, please submit a request to the QIO (KEPRO) for prior authorization:

CODE	DESCRIPTION
15823	BLEPHAROPLASTY, UP LID SKIN WT DOWN LID
15830	EXCISION EXCESSIVE SKIN/SUBCUT TISS, ABDOMEN
19300	GYNECOMASTIA MASTECTOMY (REM BREAST TIS)
19301	PARTIAL MASTECTOMY
19302	P-MASTECTOMY W/LN REMOVAL
19303	SIMPLE COMPLETE MASTECTOMY
19304	SQ MASTECTOMY
19305	RADICAL MASTECTOMY
19307	MODIFIED RADICAL MASTECTOMY
19316	MASTOPEXY, REPAIR AND RECONSTRUCT
19318	REDUCTION MAMMAPLASTY
19328	REMOVAL INTACT MAMMARY IMPLANT
19330	REMOVAL OF IMPLANT MATERIAL
19340	IMMED INSRT BREAST PROSTHES FOLLOW MAST
19342	DELAYED INSERT BREAST IMPLANT AFTER MAST
19350	NIPPLE/AREOLA RECONSTRUCTION-
19355	CORRECTION OF INVERTED NIPPLE
19357	BREAST RECON TIS EXP INC SUBSEQ EXP
19361	BREAST RECON LATI DOR FLAP W/PROS IMPLA
19364	BREAST RECON W/FREE FLAP
19366	BREAST RECON W OTHER TECHNIQUE
19367	BREAST RECONS W/TRAV RECTUS ABDOM MYOCUT
19368	BREAST RECONS W/TRAM SING PEDI W/MICROVA
19369	BREAST RECONS W/TRAM DOUBLE PEDICLE INC
19370	SURGERY FOR BREAST CAPSULE
19371	REMOAL OF BREAST CAPSULE
19380	REVISION OF RECONSTR BREAST

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
21899	NECK/CHEST SURGERY
22600	NECK SPINE FUSION
22610	THORAX SPINE FUSION
22612	LUMBAR SPINE FUSION
22614	EXTRA SPINE FUSION
22630	LUMBAR SPINE FUSION
22800	FUSION OF SPINE
22802	FUSION OF SPINE
22804	FUSION OF SPINE
22808	FUSION OF SPINE
22810	FUSION OF SPINE
22812	FUSION OF SPINE
22830	EXPLORATION OF SPINAL
22840	INSERT SPINE FIXATION
22841	INSERT SPINE FIXATION
22842	INSERT SPINE FIXATION
22843	INSERT SPINE FIXATION
22844	INSERT SPINE FIXATION
22845	INSERT SPINE FIXATION
22846	INSERT SPINE FIXATION
22847	INSERT SPINE FIXATION
22848	INSERT PELV FIXATION
22849	REINSERT SPINAL FIXATION
22853	INSERTION OF INTERBODY BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH) WITH INTEGRAL ANTERIOR INSTRUMENTATION FOR DEVICE ANCHORING (EG, SCREWS, FLANGES), WHEN PERFORMED, TO INTERVERTEBRAL DISC SPACE IN CONJUNCTION WITH INTERBODY ARTHRODESIS, EACH INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22854	INSERTION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH) WITH INTEGRAL ANTERIOR INSTRUMENTATION FOR DEVICE ANCHORING (EG, SCREWS, FLANGES), WHEN PERFORMED, TO VERTEBRAL CORPECTOMY(IES) (VERTEBRAL BODY RESECTION, PARTIAL OR COMPLETE) DEFECT, IN CONJUNCTION WITH INTERBODY ARTHRODESIS, EACH CONTIGUOUS DEFECT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
22859	INSERTION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH, METHYLMETHACRYLATE) TO INTERVERTEBRAL DISC SPACE OR VERTEBRAL BODY DEFECT WITHOUT INTERBODY ARTHRODESIS, EACH CONTIGUOUS DEFECT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22899	SPINE SURGERY PROCEDURE
37788	PENILE REVAS ART W VEIN GRAFT
43644	LAP, SURG, GAST RESTRIC;W/BYPASS & ROUX-EN-Y
43645	LAP, SURG, GAST RESTRIC; BYPASS & SM INT REC
43770	LAP, SURG, GASTRIC RESTRC PROC, PLC ADJ BAND
43771	LAP, SURG, GASTRIC RESTRC PROC, REV ADJ BAND
43773	LAP, SURG, GASTRIC RESTRC PROC; REMV-REPL BND
43842	GASTRIC RESTRIC PROC, V-BAND GASTROPLASTY
43847	GASTRIC RESTRIC PROC, SM INTES RECONSTRUC
51925	CLOS VESICOUTERINE FISTULA W HYSTERECTOM
54235	INJECT CORPORA CAVRN W PHARM AGENTS(S)
54400	INSERT PENILE PROSTH NON-INFLAT (SEMI-RIG)
54401	INSERT PENILE PROSTH INFLAT SLF-CONT
54405	INSERT MULTI-COMPONEN, INFLAT PENILE PROS
54690	LAPAROXCOPY SURGICAL ORCHIECTOMY
57291	CONSTRUCTION ARTIFICIAL VAGINA WITHOUT GRAF
57292	CONSTRUCTION ARTIFICIAL VAGINA WITH GRAF
57295	REV OF PROSTH VAG GRAFT, VAGINAL APPROACH
58180	SUPRACERVICAL HYSTERECTOMY
58260	VAGINAL HYSTERECTOMY; UTERUS <=250 GRAMS
58262	VAGINAL HYSTER., REMOVE TUBES &/OR OVARYS
58263	VAG HYST, REMV TUB/OVAR&ENTEROCELE REPAIR
58267	VAG HYST W/URINARY REPAIR
58270	VAG HYST W/ENTEROCELE REPAIR
58275	VAG HYSTER, W/TOTAL-PARTIAL VAGINECTOMY
58280	VAG HYSTER W/COLPECT W/REPAIR OF ENTEROCE
58285	VAG HYSTER RADICAL SCHAUTA TYPE OPERAT
58290	VAGINAL HYSTERECTOMY, FOR UTERUS >250 GM
58291	VAG HYSTERECTMY,UTER>250 GM, REMV TUB&OVAR

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
58293	VAG HYSTERECTMY, W/COLPO-URETHROCYSTOPEXY
58294	VAGINAL HYSTERECTOMY, REPAIR ENTEROCELE
58541	LAPAROSCOPY, SUPRACERV HYSTERECTOMY, 250G<
58542	LAP, SUPRACERV HYSTER, 250G<,REMO TUBE/OVA
58543	LAPAPROSCOPY,SUPERACERV HYSTERECTMY,>250G
58544	LAP,SUPRACERV HYSTER, >250 G, REMO TUBE/OVA
58548	LAPROSCOPY, RADICAL HYSTERECTOMY
58550	LAPROSCOPY SURGICAL, W/VAGINAL HYSTERECTM
58552	LAPAROSCOPY, VAG HYSTERECTOMY/TUBES/OVARI
58553	LAPAROSCOPY VAG HYSTERECTOMY, COMPLEX
58554	LAP VAG HYSTERECTOMY, REMV TUB&OVA COMPLX
58570	LAP, SURG, W/TOTAL TLH, UTER<=250G HYSTEREC
58571	LAP, W/TOTAL HYST, UT<=250G HYST, TUBE REMV
58572	LAP, W/TOTAL HYSTERECTOMY, UTERUS > 250G
58573	LAP, W/TOT HYSTERECY, UT>250G; REM TUBE/OVA
58575	REMOVAL OF UTERUS FOR TUMOR DEBULKING USING A LAPAROSCOPE
58952	RESECT OVARI PERIT MALIGN/RADICA DISSECT
58953	BILAT SALP-OOPH, TAH & DISECT FOR DEBLKNG
58954	BILAT SALP-OOPH, TAH & DISECT; LYMPHDECTMY
58956	BIL SAL-OOPH W OMENT., ABD HYST F MALIGN
61885	OMCOS & SUBCUT PLACEM CRANIAL NEUROSTIMULA
61886	CRANIAL NEUROSTUM PUL GEN REC INCIS SUBCT
63001	REMOVAL OF SPINAL LAMINA
63003	REMOVAL OF SPINAL LAMINA
63005	REMOVAL OF SPINAL LAMINA
63011	REMOVAL OF SPINAL LAMINA
63012	REMOVAL OF SPINAL LAMINA
63015	REMOVAL OF SPINAL LAMINA
63016	REMOVAL OF SPINAL LAMINA
63017	REMOVAL OF SPINAL LAMINA
63020	NECK SPINE DISK SURGERY
63030	LOW BACK DISK SURGERY

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
63035	SPINAL DISK SURGERY ADD ON
63040	SINGLE CERVIAL LAMINOTOMY
63042	SINGLE LUMBAR LAMINOTOMY
63045	REMOVAL OF SPINAL LAMINA
63046	REMOVAL OF SPINAL LAMINA
63047	REMOVAL OF SPINAL LAMINA
63050	CERVICAL LAMINOPLASTY
63051	C-LAMINOPLASTY WITH GRAPH/PLATE
63055	DECOMPRESS SPINAL CORD
63056	DECOMPRESS SPINAL CORD
63064	DECOMPRESS SPINAL CORD
63075	NECK SPINE DISK SURGERY
63077	THORAX SPINE DISK SURGERY
63081	REMOVAL OF VERTEBRAL BODY
63085	REMOVAL OF VERTEBRAL BODY
63087	REMOVAL OF VERTEBRAL BODY
63090	REMOVAL OF VERTEBRAL BODY
63170	INCISE SPINAL CORD TRACT(S)
63172	DRAINAGE OF SPINA CYST
63173	DRAINAGE OF SPINA CYST
63180	REVISE SPINAL CORD LIGAMENTS
63182	REVISE SPINAL CORD LIGAMENTS
63185	INCISE SPINAL COLUMN/NERVES
63190	INCISE SPINAL
63191	INCISE SPINAL
63194	INCISE SPINAL COLUMN &
63195	INCISE SPINAL COLUMN &
63196	INCISE SPINAL COLUMN &
63197	INCISE SPINAL COLUMN &
63198	INCISE SPINAL COLUMN &
63199	INCISE SPINAL COLUMN &
63200	INCISE SPINAL COLUMN &

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
63650	PERC IMPLANTATION NEUROSTIM ELECTRODES
63655	LAMINECTOMY IMPLANTATION NEUROSTIM ELECT
63661	REMV SPINAL NEUROSTIM ELEC PERCUT ARRAY
63662	REMV SPINAL NEUROSTIM ELEC PLATE VIA LAM
63663	REV W/REPL, SPIN NEUTOSTIM ELEC PERCUT AR
63664	REV W/REPL, SPIN NEUROSTIM ELEC PLATE/PAD
63685	INCIS SUBCUTAN SPINAL NEUROSTIM GENERATO
63688	REV/REM SPINAL NEUROSTIM GEMERA/RECIEVER
69300	OTOPLASTY, PROTRUDING EAR; W/WO REDUCTION
69710	IMPLANT-REPLA BONE CONDUCT DEVICE TEMPOR
69714	IMPLANT, OSSEOINTEGRATE;W/O MASTOIDECTOMY
69715	IMPLANT, OSSEOINTEGRATE;W/MASTOIDECTOMY
69718	REPLACE, OSSEOINTEGR IMPL; W/MASTOIDECTO
69930	COCHLEAR DEVICE IMPLANT W/WO MASTOIDECTO

ICD-10-PCS PRIOR AUTHORIZATION CODES

October 2017 Update

For dates of service on or after **October 1, 2017**, the following ICD-10-PCS codes require prior authorization from KEPRO. For dates of service prior to October 1, 2017, refer to the October 2016 Update included in this section.

ICD-10 CODE	DESCRIPTION
02HA0QZ	INSERTION OF IMPLANT HEART ASSIST INTO HEART, OPEN APPROACH
02HA0RJ	INSERTION OF SHORT-TERM EXTERNAL HEART ASSIST SYSTEM INTO HEART, INTRAOPERATIVE, OPEN APPROACH
02HA0RS	INSERT OF BIVENT EXT HEART ASSIST INTO HEART, OPEN APPROACH
02HA0RZ	INSERTION OF EXT HEART ASSIST INTO HEART, OPEN APPROACH
02HA0YZ	INSERTION OF OTHER DEVICE INTO HEART, OPEN APPROACH
02HA3QZ	INSERTION OF IMPLANT HEART ASSIST INTO HEART, PERC APPROACH
02HA3RJ	INSERTION OF SHORT-TERM EXTERNAL HEART ASSIST SYSTEM INTO HEART, INTRAOPERATIVE, PERCUTANEOUS APPROACH
02HA3RS	INSERT OF BIVENT EXT HEART ASSIST INTO HEART, PERC APPROACH
02HA3RZ	INSERTION OF EXT HEART ASSIST INTO HEART, PERC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
02HA3YZ	INSERTION OF OTHER DEVICE INTO HEART, PERCUTANEOUS APPROACH
02HA4QZ	INSERT IMPLANT HEART ASSIST IN HEART, PERC ENDO
02HA4RJ	INSERTION OF SHORT-TERM EXTERNAL HEART ASSIST SYSTEM INTO HEART, INTRAOPERATIVE, PERCUTANEOUS ENDOSCOPIC APPROACH
02HA4RS	INSERT BIVENT EXT HEART ASSIST IN HEART, PERC ENDO
02HA4RZ	INSERTION OF EXT HEART ASSIST INTO HEART, PERC ENDO APPROACH
02HA4YZ	INSERTION OF OTHER DEVICE INTO HEART, PERCUTANEOUS ENDOSCOPIC APPROACH
02PA0RS	REMOVAL OF BIVENTRICULAR SHORT-TERM EXTERNAL HEART ASSIST SYSTEM FROM HEART, OPEN APPROACH
02PA0RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, OPEN APPROACH
02PA0YZ	REMOVAL OF OTHER DEVICE FROM HEART, OPEN APPROACH
02PA3RS	REMOVAL OF BIVENTRICULAR SHORT-TERM EXTERNAL HEART ASSIST SYSTEM FROM HEART, PERCUTANEOUS APPROACH
02PA3RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, PERC APPROACH
02PA3YZ	REMOVAL OF OTHER DEVICE FROM HEART, PERCUTANEOUS APPROACH
02PA4RS	REMOVAL OF BIVENTRICULAR SHORT-TERM EXTERNAL HEART ASSIST SYSTEM FROM HEART, PERCUTANEOUS ENDOSCOPIC APPROACH
02PA4RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, PERC ENDO APPROACH
02PA4YZ	REMOVAL OF OTHER DEVICE FROM HEART, PERCUTANEOUS ENDOSCOPIC APPROACH
02YA0Z0	TRANSPLANTATION OF HEART, ALLOGENEIC, OPEN APPROACH
02YA0Z1	TRANSPLANTATION OF HEART, SYNGENEIC, OPEN APPROACH
02YA0Z2	TRANSPLANTATION OF HEART, ZOOPLASTIC, OPEN APPROACH
0BYC0Z0	TRANSPLANTATION OF R UP LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYC0Z1	TRANSPLANTATION OF R UP LUNG LOBE, SYNGEN, OPEN APPROACH
0BYC0Z2	TRANSPLANTATION OF R UP LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYD0Z0	TRANSPLANTATION OF R MID LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYD0Z1	TRANSPLANTATION OF R MID LUNG LOBE, SYNGEN, OPEN APPROACH
0BYD0Z2	TRANSPLANTATION OF R MID LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYF0Z0	TRANSPLANTATION OF R LOW LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYF0Z1	TRANSPLANTATION OF R LOW LUNG LOBE, SYNGEN, OPEN APPROACH
0BYF0Z2	TRANSPLANTATION OF R LOW LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYG0Z0	TRANSPLANTATION OF L UP LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYG0Z1	TRANSPLANTATION OF L UP LUNG LOBE, SYNGEN, OPEN APPROACH
0BYG0Z2	TRANSPLANTATION OF L UP LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYH0Z0	TRANSPLANTATION OF LUNG LINGULA, ALLOGENEIC, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0BYH0Z1	TRANSPLANTATION OF LUNG LINGULA, SYNGENEIC, OPEN APPROACH
0BYH0Z2	TRANSPLANTATION OF LUNG LINGULA, ZOOPLASTIC, OPEN APPROACH
0BYJ0Z0	TRANSPLANTATION OF L LOW LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYJ0Z1	TRANSPLANTATION OF L LOW LUNG LOBE, SYNGEN, OPEN APPROACH
0BYJ0Z2	TRANSPLANTATION OF L LOW LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYK0Z0	TRANSPLANTATION OF RIGHT LUNG, ALLOGENEIC, OPEN APPROACH
0BYK0Z1	TRANSPLANTATION OF RIGHT LUNG, SYNGENEIC, OPEN APPROACH
0BYK0Z2	TRANSPLANTATION OF RIGHT LUNG, ZOOPLASTIC, OPEN APPROACH
0BYL0Z0	TRANSPLANTATION OF LEFT LUNG, ALLOGENEIC, OPEN APPROACH
0BYL0Z1	TRANSPLANTATION OF LEFT LUNG, SYNGENEIC, OPEN APPROACH
0BYL0Z2	TRANSPLANTATION OF LEFT LUNG, ZOOPLASTIC, OPEN APPROACH
0BYM0Z0	TRANSPLANTATION OF BILATERAL LUNGS, ALLOGEN, OPEN APPROACH
0BYM0Z1	TRANSPLANTATION OF BILATERAL LUNGS, SYNGENEIC, OPEN APPROACH
0BYM0Z2	TRANSPLANTATION OF BILATERAL LUNGS, ZOOPLAST, OPEN APPROACH
0DL80CZ	OCCLUSION OF SMALL INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DL80DZ	OCCLUSION OF SMALL INTEST WITH INTRALUM DEV, OPEN APPROACH
0DL80ZZ	OCCLUSION OF SMALL INTESTINE, OPEN APPROACH
0DL83CZ	OCCLUSION OF SMALL INTEST WITH EXTRALUM DEV, PERC APPROACH
0DL83DZ	OCCLUSION OF SMALL INTEST WITH INTRALUM DEV, PERC APPROACH
0DL83ZZ	OCCLUSION OF SMALL INTESTINE, PERCUTANEOUS APPROACH
0DL84CZ	OCCLUSION SMALL INTEST W EXTRALUM DEV, PERC ENDO
0DL84DZ	OCCLUSION SMALL INTEST W INTRALUM DEV, PERC ENDO
0DL84ZZ	OCCLUSION OF SMALL INTESTINE, PERC ENDO APPROACH
0DL87DZ	OCCLUSION OF SMALL INTESTINE WITH INTRALUM DEV, VIA OPENING
0DL87ZZ	OCCLUSION OF SMALL INTESTINE, VIA OPENING
0DL88DZ	OCCLUSION OF SMALL INTESTINE WITH INTRALUMINAL DEVICE, ENDO
0DL88ZZ	OCCLUSION OF SMALL INTESTINE, ENDO
0DL90CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, OPEN APPROACH
0DL90DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, OPEN APPROACH
0DL90ZZ	OCCLUSION OF DUODENUM, OPEN APPROACH
0DL93CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, PERC APPROACH
0DL93DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, PERC APPROACH
0DL93ZZ	OCCLUSION OF DUODENUM, PERCUTANEOUS APPROACH
0DL94CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, PERC ENDO APPROACH APPROACH
0DL94DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, PERC ENDO

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DL94ZZ	OCCLUSION OF DUODENUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DL97DZ	OCCLUSION OF DUODENUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DL97ZZ	OCCLUSION OF DUODENUM, VIA NATURAL OR ARTIFICIAL OPENING
0DL98DZ	OCCLUSION OF DUODENUM WITH INTRALUMINAL DEVICE, ENDO
0DL98ZZ	OCCLUSION OF DUODENUM, ENDO
0DLA0CZ	OCCLUSION OF JEJUNUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLA0DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, OPEN APPROACH
0DLA0ZZ	OCCLUSION OF JEJUNUM, OPEN APPROACH
0DLA3CZ	OCCLUSION OF JEJUNUM WITH EXTRALUMINAL DEVICE, PERC APPROACH APPROACH
0DLA3DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, PERC
0DLA3ZZ	OCCLUSION OF JEJUNUM, PERCUTANEOUS APPROACH
0DLA4CZ	OCCLUSION OF JEJUNUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLA4DZ	OCCLUSION OF JEJUNUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLA4ZZ	OCCLUSION OF JEJUNUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLA7DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLA7ZZ	OCCLUSION OF JEJUNUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLA8DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, ENDO
0DLA8ZZ	OCCLUSION OF JEJUNUM, ENDO
0DLB0CZ	OCCLUSION OF ILEUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLB0DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, OPEN APPROACH
0DLB0ZZ	OCCLUSION OF ILEUM, OPEN APPROACH
0DLB3CZ	OCCLUSION OF ILEUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLB3DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, PERC APPROACH
0DLB3ZZ	OCCLUSION OF ILEUM, PERCUTANEOUS APPROACH
0DLB4CZ	OCCLUSION OF ILEUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLB4DZ	OCCLUSION OF ILEUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLB4ZZ	OCCLUSION OF ILEUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLB7DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLB7ZZ	OCCLUSION OF ILEUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLB8DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, ENDO
0DLB8ZZ	OCCLUSION OF ILEUM, ENDO
0DLC0CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, OPEN
0DLC0DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, OPEN
0DLC0ZZ	OCCLUSION OF ILEOCECAL VALVE, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLC3CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, PERC
0DLC3DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, PERC
0DLC3ZZ	OCCLUSION OF ILEOCECAL VALVE, PERCUTANEOUS APPROACH
0DLC4CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, PERC ENDO
0DLC4DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, PERC ENDO
0DLC4ZZ	OCCLUSION OF ILEOCECAL VALVE, PERC ENDO APPROACH
0DLC7DZ	OCCLUSION OF ILEOCECAL VALVE WITH INTRALUM DEV, VIA OPENING
0DLC7ZZ	OCCLUSION OF ILEOCECAL VALVE, VIA OPENING
0DLC8DZ	OCCLUSION OF ILEOCECAL VALVE WITH INTRALUMINAL DEVICE, ENDO
0DLC8ZZ	OCCLUSION OF ILEOCECAL VALVE, ENDO
0DLE0CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLE0DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLE0ZZ	OCCLUSION OF LARGE INTESTINE, OPEN APPROACH
0DLE3CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLE3DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLE3ZZ	OCCLUSION OF LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLE4CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLE4DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, PERC ENDO APPROACH
0DLE4ZZ	OCCLUSION OF LARGE INTESTINE, PERC ENDO APPROACH
0DLE7DZ	OCCLUSION OF LARGE INTESTINE WITH INTRALUM DEV, VIA OPENING
0DLE7ZZ	OCCLUSION OF LARGE INTESTINE, VIA OPENING
0DLE8DZ	OCCLUSION OF LARGE INTESTINE WITH INTRALUMINAL DEVICE, ENDO
0DLE8ZZ	OCCLUSION OF LARGE INTESTINE, ENDO
0DLF0CZ	OCCLUSION OF R LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLF0DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLF0ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, OPEN APPROACH
0DLF3CZ	OCCLUSION OF R LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLF3DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLF3ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLF4CZ	OCCLUSION R LG INTEST W EXTRALUM DEV, PERC ENDO
0DLF4DZ	OCCLUSION R LG INTEST W INTRALUM DEV, PERC ENDO
0DLF4ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, PERC ENDO APPROACH
0DLF7DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, VIA OPENING
0DLF7ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, VIA OPENING
0DLF8DZ	OCCLUSION OF RIGHT LARGE INTESTINE WITH INTRALUM DEV, ENDO
0DLF8ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, ENDO
0DLG0CZ	OCCLUSION OF L LG INTEST WITH EXTRALUM DEV, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLG0DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLG0ZZ	OCCLUSION OF LEFT LARGE INTESTINE, OPEN APPROACH
0DLG3CZ	OCCLUSION OF L LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLG3DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLG3ZZ	OCCLUSION OF LEFT LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLG4CZ	OCCLUSION L LG INTEST W EXTRALUM DEV, PERC ENDO
0DLG4DZ	OCCLUSION L LG INTEST W INTRALUM DEV, PERC ENDO
0DLG4ZZ	OCCLUSION OF LEFT LARGE INTESTINE, PERC ENDO APPROACH
0DLG7DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, VIA OPENING
0DLG7ZZ	OCCLUSION OF LEFT LARGE INTESTINE, VIA OPENING
0DLG8DZ	OCCLUSION OF LEFT LARGE INTESTINE WITH INTRALUM DEV, ENDO
0DLG8ZZ	OCCLUSION OF LEFT LARGE INTESTINE, ENDO
0DLH0CZ	OCCLUSION OF CECUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH APPROACH
0DLH0DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, OPEN
0DLH0ZZ	OCCLUSION OF CECUM, OPEN APPROACH
0DLH3CZ	OCCLUSION OF CECUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLH3DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, PERC APPROACH
0DLH3ZZ	OCCLUSION OF CECUM, PERCUTANEOUS APPROACH
0DLH4CZ	OCCLUSION OF CECUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLH4DZ	OCCLUSION OF CECUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLH4ZZ	OCCLUSION OF CECUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLH7DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLH7ZZ	OCCLUSION OF CECUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLH8DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, ENDO
0DLH8ZZ	OCCLUSION OF CECUM, ENDO
0DLK0CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLK0DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, OPEN APPROACH
0DLK0ZZ	OCCLUSION OF ASCENDING COLON, OPEN APPROACH
0DLK3CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, PERC APPROACH
0DLK3DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, PERC APPROACH
0DLK3ZZ	OCCLUSION OF ASCENDING COLON, PERCUTANEOUS APPROACH
0DLK4CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLK4DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, PERC ENDO APPROACH
0DLK4ZZ	OCCLUSION OF ASCENDING COLON, PERC ENDO APPROACH
0DLK7DZ	OCCLUSION OF ASCENDING COLON WITH INTRALUM DEV, VIA OPENING
0DLK7ZZ	OCCLUSION OF ASCENDING COLON, VIA OPENING

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLK8DZ	OCCLUSION OF ASCENDING COLON WITH INTRALUMINAL DEVICE, ENDO
0DLK8ZZ	OCCLUSION OF ASCENDING COLON, ENDO
0DLL0CZ	OCCLUSION OF TRANS COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLL0DZ	OCCLUSION OF TRANS COLON WITH INTRALUM DEV, OPEN APPROACH
0DLL0ZZ	OCCLUSION OF TRANSVERSE COLON, OPEN APPROACH
0DLL3CZ	OCCLUSION OF TRANS COLON WITH EXTRALUM DEV, PERC APPROACH
0DLL3DZ	OCCLUSION OF TRANS COLON WITH INTRALUM DEV, PERC APPROACH
0DLL3ZZ	OCCLUSION OF TRANSVERSE COLON, PERCUTANEOUS APPROACH
0DLL4CZ	OCCLUSION TRANS COLON W EXTRALUM DEV, PERC ENDO
0DLL4DZ	OCCLUSION TRANS COLON W INTRALUM DEV, PERC ENDO
0DLL4ZZ	OCCLUSION OF TRANSVERSE COLON, PERC ENDO APPROACH
0DLL7DZ	OCCLUSION OF TRANSVERSE COLON WITH INTRALUM DEV, VIA OPENING
0DLL7ZZ	OCCLUSION OF TRANSVERSE COLON, VIA OPENING
0DLL8DZ	OCCLUSION OF TRANSVERSE COLON WITH INTRALUMINAL DEVICE, ENDO
0DLL8ZZ	OCCLUSION OF TRANSVERSE COLON, ENDO
0DLM0CZ	OCCLUSION OF DESCEND COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLM0DZ	OCCLUSION OF DESCEND COLON WITH INTRALUM DEV, OPEN APPROACH
0DLM0ZZ	OCCLUSION OF DESCENDING COLON, OPEN APPROACH
0DLM3CZ	OCCLUSION OF DESCEND COLON WITH EXTRALUM DEV, PERC APPROACH
0DLM3DZ	OCCLUSION OF DESCEND COLON WITH INTRALUM DEV, PERC APPROACH
0DLM3ZZ	OCCLUSION OF DESCENDING COLON, PERCUTANEOUS APPROACH
0DLM4CZ	OCCLUSION DESCEND COLON W EXTRALUM DEV, PERC ENDO
0DLM4DZ	OCCLUSION DESCEND COLON W INTRALUM DEV, PERC ENDO
0DLM4ZZ	OCCLUSION OF DESCENDING COLON, PERC ENDO APPROACH
0DLM7DZ	OCCLUSION OF DESCENDING COLON WITH INTRALUM DEV, VIA OPENING
0DLM7ZZ	OCCLUSION OF DESCENDING COLON, VIA OPENING
0DLM8DZ	OCCLUSION OF DESCENDING COLON WITH INTRALUMINAL DEVICE, ENDO
0DLM8ZZ	OCCLUSION OF DESCENDING COLON, ENDO
0DLN0CZ	OCCLUSION OF SIGMOID COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLN0DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, OPEN APPROACH
0DLN0ZZ	OCCLUSION OF SIGMOID COLON, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLN3CZ	OCCLUSION OF SIGMOID COLON WITH EXTRALUM DEV, PERC APPROACH
0DLN3DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, PERC APPROACH
0DLN3ZZ	OCCLUSION OF SIGMOID COLON, PERCUTANEOUS APPROACH
0DLN4CZ	OCCLUSION SIGMOID COLON W EXTRALUM DEV, PERC ENDO
0DLN4DZ	OCCLUSION SIGMOID COLON W INTRALUM DEV, PERC ENDO
0DLN4ZZ	OCCLUSION OF SIGMOID COLON, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLN7DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, VIA OPENING
0DLN7ZZ	OCCLUSION OF SIGMOID COLON, VIA OPENING
0DLN8DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUMINAL DEVICE, ENDO
0DLN8ZZ	OCCLUSION OF SIGMOID COLON, ENDO
0DQ80ZZ	REPAIR SMALL INTESTINE, OPEN APPROACH
0DQ83ZZ	REPAIR SMALL INTESTINE, PERCUTANEOUS APPROACH
0DQ84ZZ	REPAIR SMALL INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH
0DQ87ZZ	REPAIR SMALL INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DQ88ZZ	REPAIR SMALL INTESTINE, ENDO
0DQE0ZZ	REPAIR LARGE INTESTINE, OPEN APPROACH
0DQE3ZZ	REPAIR LARGE INTESTINE, PERCUTANEOUS APPROACH
0DQE4ZZ	REPAIR LARGE INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH
0DQE7ZZ	REPAIR LARGE INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DQE8ZZ	REPAIR LARGE INTESTINE, ENDO
0DS80ZZ	REPOSITION SMALL INTESTINE, OPEN APPROACH
0DS84ZZ	REPOSITION SMALL INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH
0DS87ZZ	REPOSITION SMALL INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DS88ZZ	REPOSITION SMALL INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0DSE0ZZ	REPOSITION LARGE INTESTINE, OPEN APPROACH
0DSE4ZZ	REPOSITION LARGE INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH
0DSE7ZZ	REPOSITION LARGE INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DSE8ZZ	REPOSITION LARGE INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0DT80ZZ	RESECTION OF SMALL INTESTINE, OPEN APPROACH
0DT84ZZ	RESECTION OF SMALL INTESTINE, PERC ENDO APPROACH
0DT87ZZ	RESECTION OF SMALL INTESTINE, VIA OPENING
0DT88ZZ	RESECTION OF SMALL INTESTINE, ENDO
0DT90ZZ	RESECTION OF DUODENUM, OPEN APPROACH
0DT94ZZ	RESECTION OF DUODENUM, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DT97ZZ	RESECTION OF DUODENUM, VIA NATURAL OR ARTIFICIAL OPENING
0DT98ZZ	RESECTION OF DUODENUM, ENDO
0DTN0ZZ	RESECTION OF SIGMOID COLON, OPEN APPROACH
0DTP0ZZ	RESECTION OF RECTUM, OPEN APPROACH
0DY80Z0	TRANSPLANTATION OF SMALL INTESTINE, ALLOGEN, OPEN APPROACH
0DY80Z1	TRANSPLANTATION OF SMALL INTESTINE, SYNGENEIC, OPEN APPROACH
0DY80Z2	TRANSPLANTATION OF SMALL INTESTINE, ZOOPLAST, OPEN APPROACH
0DYE0Z0	TRANSPLANTATION OF LARGE INTESTINE, ALLOGEN, OPEN APPROACH
0DYE0Z1	TRANSPLANTATION OF LARGE INTESTINE, SYNGENEIC, OPEN APPROACH
0DYE0Z2	TRANSPLANTATION OF LARGE INTESTINE, ZOOPLAST, OPEN APPROACH
0FB00ZZ	EXCISION OF LIVER, OPEN APPROACH
0FB03ZZ	EXCISION OF LIVER, PERCUTANEOUS APPROACH
0FB04ZZ	EXCISION OF LIVER, PERCUTANEOUS ENDOSCOPIC APPROACH
0FB10ZZ	EXCISION OF RIGHT LOBE LIVER, OPEN APPROACH
0FB13ZZ	EXCISION OF RIGHT LOBE LIVER, PERCUTANEOUS APPROACH
0FB14ZZ	EXCISION OF RIGHT LOBE LIVER, PERC ENDO APPROACH
0FB20ZZ	EXCISION OF LEFT LOBE LIVER, OPEN APPROACH
0FB23ZZ	EXCISION OF LEFT LOBE LIVER, PERCUTANEOUS APPROACH
0FB24ZZ	EXCISION OF LEFT LOBE LIVER, PERC ENDO APPROACH
0FBG0ZZ	EXCISION OF PANCREAS, OPEN APPROACH
0FBG3ZZ	EXCISION OF PANCREAS, PERCUTANEOUS APPROACH
0FBG4ZZ	EXCISION OF PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FBG8ZZ	EXCISION OF PANCREAS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0FSG0ZZ	REPOSITION PANCREAS, OPEN APPROACH
0FSG4ZZ	REPOSITION PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FT00ZZ	RESECTION OF LIVER, OPEN APPROACH
0FT04ZZ	RESECTION OF LIVER, PERCUTANEOUS ENDOSCOPIC APPROACH
0FT10ZZ	RESECTION OF RIGHT LOBE LIVER, OPEN APPROACH
0FT14ZZ	RESECTION OF RIGHT LOBE LIVER, PERC ENDO APPROACH
0FT20ZZ	RESECTION OF LEFT LOBE LIVER, OPEN APPROACH
0FT24ZZ	RESECTION OF LEFT LOBE LIVER, PERC ENDO APPROACH
0FTG0ZZ	RESECTION OF PANCREAS, OPEN APPROACH
0FTG4ZZ	RESECTION OF PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FY00Z0	TRANSPLANTATION OF LIVER, ALLOGENEIC, OPEN APPROACH
0FY00Z1	TRANSPLANTATION OF LIVER, SYNGENEIC, OPEN APPROACH
0FY00Z2	TRANSPLANTATION OF LIVER, ZOOPLASTIC, OPEN APPROACH
0FYG0Z0	TRANSPLANTATION OF PANCREAS, ALLOGENEIC, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0FYG0Z1	TRANSPLANTATION OF PANCREAS, SYNGENEIC, OPEN APPROACH
0FYG0Z2	TRANSPLANTATION OF PANCREAS, ZOOPLASTIC, OPEN APPROACH
0KXF0Z5	TRANSFER RIGHT TRUNK MUSCLE, LATISSIMUS DORSI MYOCUTANEOUS FLAP, OPEN APPROACH
0KXF0Z7	TRANSFER RIGHT TRUNK MUSCLE, DEEP INFERIOR EPIGASTRIC ARTERY PERFORATOR FLAP, OPEN APPROACH
0KXF0Z8	TRANSFER RIGHT TRUNK MUSCLE, SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP, OPEN APPROACH
0KXF0Z9	TRANSFER RIGHT TRUNK MUSCLE, GLUTEAL ARTERY PERFORATOR FLAP, OPEN APPROACH
0KXF4Z5	TRANSFER RIGHT TRUNK MUSCLE, LATISSIMUS DORSI MYOCUTANEOUS FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0KXF4Z7	TRANSFER RIGHT TRUNK MUSCLE, DEEP INFERIOR EPIGASTRIC ARTERY PERFORATOR FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0KXF4Z8	TRANSFER RIGHT TRUNK MUSCLE, SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0KXF4Z9	TRANSFER RIGHT TRUNK MUSCLE, GLUTEAL ARTERY PERFORATOR FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0KXG0Z5	TRANSFER LEFT TRUNK MUSCLE, LATISSIMUS DORSI MYOCUTANEOUS FLAP, OPEN APPROACH
0KXG0Z7	TRANSFER LEFT TRUNK MUSCLE, DEEP INFERIOR EPIGASTRIC ARTERY PERFORATOR FLAP, OPEN APPROACH
0KXG0Z8	TRANSFER LEFT TRUNK MUSCLE, SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP, OPEN APPROACH
0KXG0Z9	TRANSFER LEFT TRUNK MUSCLE, GLUTEAL ARTERY PERFORATOR FLAP, OPEN APPROACH
0KXG4Z5	TRANSFER LEFT TRUNK MUSCLE, LATISSIMUS DORSI MYOCUTANEOUS FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0KXG4Z7	TRANSFER LEFT TRUNK MUSCLE, DEEP INFERIOR EPIGASTRIC ARTERY PERFORATOR FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0KXG4Z8	TRANSFER LEFT TRUNK MUSCLE, SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0KXG4Z9	TRANSFER LEFT TRUNK MUSCLE, GLUTEAL ARTERY PERFORATOR FLAP, PERCUTANEOUS ENDOSCOPIC APPROACH
0TTB0ZZ	RESECTION OF BLADDER, OPEN APPROACH
0TTD0ZZ	RESECTION OF URETHRA, OPEN APPROACH
0UT40ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, OPEN APPROACH
0UT44ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UT47ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, VIA NATURAL OR ARTIFICIAL OPENING
0UT48ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0UT70ZZ	RESECTION OF BILATERAL FALLOPIAN TUBES, OPEN APPROACH
0WY20Z0	TRANSPLANTATION OF FACE, ALLOGENEIC, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0WY20Z1	TRANSPLANTATION OF FACE, SYNGENEIC, OPEN APPROACH
0XYJ0Z0	TRANSPLANTATION OF RIGHT HAND, ALLOGENEIC, OPEN APPROACH
0XYJ0Z1	TRANSPLANTATION OF RIGHT HAND, SYNGENEIC, OPEN APPROACH
0XYK0Z0	TRANSPLANTATION OF LEFT HAND, ALLOGENEIC, OPEN APPROACH
0XYK0Z1	TRANSPLANTATION OF LEFT HAND, SYNGENEIC, OPEN APPROACH
5A02116	ASSIST WITH CARDIAC OUTPUT USING OTHER PUMP, INTERMITTENT
5A02216	ASSISTANCE WITH CARDIAC OUTPUT USING OTHER PUMP, CONTINUOUS

October 2016 Update

For dates of service on or after **October 1, 2016**, the following ICD-10-PCS codes require prior authorization from KEPRO. For dates of service prior to October 1, 2016, refer to the October 2015 Update included in this section.

ICD-10 CODE	DESCRIPTION
02HA0QZ	INSERTION OF IMPLANT HEART ASSIST INTO HEART, OPEN APPROACH
02HA0RS	INSERT OF BIVENT EXT HEART ASSIST INTO HEART, OPEN APPROACH
02HA0RZ	INSERTION OF EXT HEART ASSIST INTO HEART, OPEN APPROACH
02HA3QZ	INSERTION OF IMPLANT HEART ASSIST INTO HEART, PERC APPROACH
02HA3RS	INSERT OF BIVENT EXT HEART ASSIST INTO HEART, PERC APPROACH
02HA3RZ	INSERTION OF EXT HEART ASSIST INTO HEART, PERC APPROACH
02HA4QZ	INSERT IMPLANT HEART ASSIST IN HEART, PERC ENDO
02HA4RS	INSERT BIVENT EXT HEART ASSIST IN HEART, PERC ENDO
02HA4RZ	INSERTION OF EXT HEART ASSIST INTO HEART, PERC ENDO APPROACH
02PA0RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, OPEN APPROACH
02PA3RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, PERC APPROACH
02PA4RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, PERC ENDO APPROACH
02YA0Z0	TRANSPLANTATION OF HEART, ALLOGENEIC, OPEN APPROACH
02YA0Z1	TRANSPLANTATION OF HEART, SYNGENEIC, OPEN APPROACH
02YA0Z2	TRANSPLANTATION OF HEART, ZOOPLASTIC, OPEN APPROACH
0BYC0Z0	TRANSPLANTATION OF R UP LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYC0Z1	TRANSPLANTATION OF R UP LUNG LOBE, SYNGEN, OPEN APPROACH
0BYC0Z2	TRANSPLANTATION OF R UP LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYD0Z0	TRANSPLANTATION OF R MID LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYD0Z1	TRANSPLANTATION OF R MID LUNG LOBE, SYNGEN, OPEN APPROACH
0BYD0Z2	TRANSPLANTATION OF R MID LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYF0Z0	TRANSPLANTATION OF R LOW LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYF0Z1	TRANSPLANTATION OF R LOW LUNG LOBE, SYNGEN, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0BYF0Z2	TRANSPLANTATION OF R LOW LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYG0Z0	TRANSPLANTATION OF L UP LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYG0Z1	TRANSPLANTATION OF L UP LUNG LOBE, SYNGEN, OPEN APPROACH
0BYG0Z2	TRANSPLANTATION OF L UP LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYH0Z0	TRANSPLANTATION OF LUNG LINGULA, ALLOGENEIC, OPEN APPROACH
0BYH0Z1	TRANSPLANTATION OF LUNG LINGULA, SYNGENEIC, OPEN APPROACH
0BYH0Z2	TRANSPLANTATION OF LUNG LINGULA, ZOOPLASTIC, OPEN APPROACH
0BYJ0Z0	TRANSPLANTATION OF L LOW LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYJ0Z1	TRANSPLANTATION OF L LOW LUNG LOBE, SYNGEN, OPEN APPROACH
0BYJ0Z2	TRANSPLANTATION OF L LOW LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYK0Z0	TRANSPLANTATION OF RIGHT LUNG, ALLOGENEIC, OPEN APPROACH
0BYK0Z1	TRANSPLANTATION OF RIGHT LUNG, SYNGENEIC, OPEN APPROACH
0BYK0Z2	TRANSPLANTATION OF RIGHT LUNG, ZOOPLASTIC, OPEN APPROACH
0BYL0Z0	TRANSPLANTATION OF LEFT LUNG, ALLOGENEIC, OPEN APPROACH
0BYL0Z1	TRANSPLANTATION OF LEFT LUNG, SYNGENEIC, OPEN APPROACH
0BYL0Z2	TRANSPLANTATION OF LEFT LUNG, ZOOPLASTIC, OPEN APPROACH
0BYM0Z0	TRANSPLANTATION OF BILATERAL LUNGS, ALLOGEN, OPEN APPROACH
0BYM0Z1	TRANSPLANTATION OF BILATERAL LUNGS, SYNGENEIC, OPEN APPROACH
0BYM0Z2	TRANSPLANTATION OF BILATERAL LUNGS, ZOOPLAST, OPEN APPROACH
0DL80CZ	OCCLUSION OF SMALL INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DL80DZ	OCCLUSION OF SMALL INTEST WITH INTRALUM DEV, OPEN APPROACH
0DL80ZZ	OCCLUSION OF SMALL INTESTINE, OPEN APPROACH
0DL83CZ	OCCLUSION OF SMALL INTEST WITH EXTRALUM DEV, PERC APPROACH
0DL83DZ	OCCLUSION OF SMALL INTEST WITH INTRALUM DEV, PERC APPROACH
0DL83ZZ	OCCLUSION OF SMALL INTESTINE, PERCUTANEOUS APPROACH
0DL84CZ	OCCLUSION SMALL INTEST W EXTRALUM DEV, PERC ENDO
0DL84DZ	OCCLUSION SMALL INTEST W INTRALUM DEV, PERC ENDO
0DL84ZZ	OCCLUSION OF SMALL INTESTINE, PERC ENDO APPROACH
0DL87DZ	OCCLUSION OF SMALL INTESTINE WITH INTRALUM DEV, VIA OPENING
0DL87ZZ	OCCLUSION OF SMALL INTESTINE, VIA OPENING
0DL88DZ	OCCLUSION OF SMALL INTESTINE WITH INTRALUMINAL DEVICE, ENDO
0DL88ZZ	OCCLUSION OF SMALL INTESTINE, ENDO
0DL90CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, OPEN APPROACH
0DL90DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, OPEN APPROACH
0DL90ZZ	OCCLUSION OF DUODENUM, OPEN APPROACH
0DL93CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, PERC APPROACH
0DL93DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, PERC APPROACH
0DL93ZZ	OCCLUSION OF DUODENUM, PERCUTANEOUS APPROACH
0DL94CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, PERC ENDO APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DL94DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DL94ZZ	OCCLUSION OF DUODENUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DL97DZ	OCCLUSION OF DUODENUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DL97ZZ	OCCLUSION OF DUODENUM, VIA NATURAL OR ARTIFICIAL OPENING
0DL98DZ	OCCLUSION OF DUODENUM WITH INTRALUMINAL DEVICE, ENDO
0DL98ZZ	OCCLUSION OF DUODENUM, ENDO
0DLA0CZ	OCCLUSION OF JEJUNUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLA0DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, OPEN APPROACH
0DLA0ZZ	OCCLUSION OF JEJUNUM, OPEN APPROACH
0DLA3CZ	OCCLUSION OF JEJUNUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLA3DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, PERC APPROACH
0DLA3ZZ	OCCLUSION OF JEJUNUM, PERCUTANEOUS APPROACH
0DLA4CZ	OCCLUSION OF JEJUNUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLA4DZ	OCCLUSION OF JEJUNUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLA4ZZ	OCCLUSION OF JEJUNUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLA7DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLA7ZZ	OCCLUSION OF JEJUNUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLA8DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, ENDO
0DLA8ZZ	OCCLUSION OF JEJUNUM, ENDO
0DLB0CZ	OCCLUSION OF ILEUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLB0DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, OPEN APPROACH
0DLB0ZZ	OCCLUSION OF ILEUM, OPEN APPROACH
0DLB3CZ	OCCLUSION OF ILEUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLB3DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, PERC APPROACH
0DLB3ZZ	OCCLUSION OF ILEUM, PERCUTANEOUS APPROACH
0DLB4CZ	OCCLUSION OF ILEUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLB4DZ	OCCLUSION OF ILEUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLB4ZZ	OCCLUSION OF ILEUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLB7DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLB7ZZ	OCCLUSION OF ILEUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLB8DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, ENDO
0DLB8ZZ	OCCLUSION OF ILEUM, ENDO
0DLC0CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, OPEN
0DLC0DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, OPEN
0DLC0ZZ	OCCLUSION OF ILEOCECAL VALVE, OPEN APPROACH
0DLC3CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, PERC
0DLC3DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, PERC
0DLC3ZZ	OCCLUSION OF ILEOCECAL VALVE, PERCUTANEOUS APPROACH
0DLC4CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, PERC ENDO

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLC4DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, PERC ENDO
0DLC4ZZ	OCCLUSION OF ILEOCECAL VALVE, PERC ENDO APPROACH
0DLC7DZ	OCCLUSION OF ILEOCECAL VALVE WITH INTRALUM DEV, VIA OPENING
0DLC7ZZ	OCCLUSION OF ILEOCECAL VALVE, VIA OPENING
0DLC8DZ	OCCLUSION OF ILEOCECAL VALVE WITH INTRALUMINAL DEVICE, ENDO
0DLC8ZZ	OCCLUSION OF ILEOCECAL VALVE, ENDO
0DLE0CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLE0DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLE0ZZ	OCCLUSION OF LARGE INTESTINE, OPEN APPROACH
0DLE3CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLE3DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLE3ZZ	OCCLUSION OF LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLE4CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLE4DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, PERC ENDO APPROACH
0DLE4ZZ	OCCLUSION OF LARGE INTESTINE, PERC ENDO APPROACH
0DLE7DZ	OCCLUSION OF LARGE INTESTINE WITH INTRALUM DEV, VIA OPENING
0DLE7ZZ	OCCLUSION OF LARGE INTESTINE, VIA OPENING
0DLE8DZ	OCCLUSION OF LARGE INTESTINE WITH INTRALUMINAL DEVICE, ENDO
0DLE8ZZ	OCCLUSION OF LARGE INTESTINE, ENDO
0DLF0CZ	OCCLUSION OF R LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLF0DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLF0ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, OPEN APPROACH
0DLF3CZ	OCCLUSION OF R LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLF3DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLF3ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLF4CZ	OCCLUSION R LG INTEST W EXTRALUM DEV, PERC ENDO
0DLF4DZ	OCCLUSION R LG INTEST W INTRALUM DEV, PERC ENDO
0DLF4ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, PERC ENDO APPROACH
0DLF7DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, VIA OPENING
0DLF7ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, VIA OPENING
0DLF8DZ	OCCLUSION OF RIGHT LARGE INTESTINE WITH INTRALUM DEV, ENDO
0DLF8ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, ENDO
0DLG0CZ	OCCLUSION OF L LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLG0DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLG0ZZ	OCCLUSION OF LEFT LARGE INTESTINE, OPEN APPROACH
0DLG3CZ	OCCLUSION OF L LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLG3DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLG3ZZ	OCCLUSION OF LEFT LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLG4CZ	OCCLUSION L LG INTEST W EXTRALUM DEV, PERC ENDO
0DLG4DZ	OCCLUSION L LG INTEST W INTRALUM DEV, PERC ENDO
0DLG4ZZ	OCCLUSION OF LEFT LARGE INTESTINE, PERC ENDO APPROACH
0DLG7DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, VIA OPENING

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLG7ZZ	OCCLUSION OF LEFT LARGE INTESTINE, VIA OPENING
0DLG8DZ	OCCLUSION OF LEFT LARGE INTESTINE WITH INTRALUM DEV, ENDO
0DLG8ZZ	OCCLUSION OF LEFT LARGE INTESTINE, ENDO
0DLH0CZ	OCCLUSION OF CECUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLH0DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, OPEN APPROACH
0DLH0ZZ	OCCLUSION OF CECUM, OPEN APPROACH
0DLH3CZ	OCCLUSION OF CECUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLH3DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, PERC APPROACH
0DLH3ZZ	OCCLUSION OF CECUM, PERCUTANEOUS APPROACH
0DLH4CZ	OCCLUSION OF CECUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLH4DZ	OCCLUSION OF CECUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLH4ZZ	OCCLUSION OF CECUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLH7DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLH7ZZ	OCCLUSION OF CECUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLH8DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, ENDO
0DLH8ZZ	OCCLUSION OF CECUM, ENDO
0DLK0CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLK0DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, OPEN APPROACH
0DLK0ZZ	OCCLUSION OF ASCENDING COLON, OPEN APPROACH
0DLK3CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, PERC APPROACH
0DLK3DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, PERC APPROACH
0DLK3ZZ	OCCLUSION OF ASCENDING COLON, PERCUTANEOUS APPROACH
0DLK4CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLK4DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, PERC ENDO APPROACH
0DLK4ZZ	OCCLUSION OF ASCENDING COLON, PERC ENDO APPROACH
0DLK7DZ	OCCLUSION OF ASCENDING COLON WITH INTRALUM DEV, VIA OPENING
0DLK7ZZ	OCCLUSION OF ASCENDING COLON, VIA OPENING
0DLK8DZ	OCCLUSION OF ASCENDING COLON WITH INTRALUMINAL DEVICE, ENDO
0DLK8ZZ	OCCLUSION OF ASCENDING COLON, ENDO
0DLL0CZ	OCCLUSION OF TRANS COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLL0DZ	OCCLUSION OF TRANS COLON WITH INTRALUM DEV, OPEN APPROACH
0DLL0ZZ	OCCLUSION OF TRANSVERSE COLON, OPEN APPROACH
0DLL3CZ	OCCLUSION OF TRANS COLON WITH EXTRALUM DEV, PERC APPROACH
0DLL3DZ	OCCLUSION OF TRANS COLON WITH INTRALUM DEV, PERC APPROACH
0DLL3ZZ	OCCLUSION OF TRANSVERSE COLON, PERCUTANEOUS APPROACH
0DLL4CZ	OCCLUSION TRANS COLON W EXTRALUM DEV, PERC ENDO
0DLL4DZ	OCCLUSION TRANS COLON W INTRALUM DEV, PERC ENDO
0DLL4ZZ	OCCLUSION OF TRANSVERSE COLON, PERC ENDO APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLL7DZ	OCCLUSION OF TRANSVERSE COLON WITH INTRALUM DEV, VIA OPENING
0DLL7ZZ	OCCLUSION OF TRANSVERSE COLON, VIA OPENING
0DLL8DZ	OCCLUSION OF TRANSVERSE COLON WITH INTRALUMINAL DEVICE, ENDO
0DLL8ZZ	OCCLUSION OF TRANSVERSE COLON, ENDO
0DLM0CZ	OCCLUSION OF DESCEND COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLM0DZ	OCCLUSION OF DESCEND COLON WITH INTRALUM DEV, OPEN APPROACH
0DLM0ZZ	OCCLUSION OF DESCENDING COLON, OPEN APPROACH
0DLM3CZ	OCCLUSION OF DESCEND COLON WITH EXTRALUM DEV, PERC APPROACH
0DLM3DZ	OCCLUSION OF DESCEND COLON WITH INTRALUM DEV, PERC APPROACH
0DLM3ZZ	OCCLUSION OF DESCENDING COLON, PERCUTANEOUS APPROACH
0DLM4CZ	OCCLUSION DESCEND COLON W EXTRALUM DEV, PERC ENDO
0DLM4DZ	OCCLUSION DESCEND COLON W INTRALUM DEV, PERC ENDO
0DLM4ZZ	OCCLUSION OF DESCENDING COLON, PERC ENDO APPROACH
0DLM7DZ	OCCLUSION OF DESCENDING COLON WITH INTRALUM DEV, VIA OPENING
0DLM7ZZ	OCCLUSION OF DESCENDING COLON, VIA OPENING
0DLM8DZ	OCCLUSION OF DESCENDING COLON WITH INTRALUMINAL DEVICE, ENDO
0DLM8ZZ	OCCLUSION OF DESCENDING COLON, ENDO
0DLN0CZ	OCCLUSION OF SIGMOID COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLN0DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, OPEN APPROACH
0DLN0ZZ	OCCLUSION OF SIGMOID COLON, OPEN APPROACH
0DLN3CZ	OCCLUSION OF SIGMOID COLON WITH EXTRALUM DEV, PERC APPROACH
0DLN3DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, PERC APPROACH
0DLN3ZZ	OCCLUSION OF SIGMOID COLON, PERCUTANEOUS APPROACH
0DLN4CZ	OCCLUSION SIGMOID COLON W EXTRALUM DEV, PERC ENDO
0DLN4DZ	OCCLUSION SIGMOID COLON W INTRALUM DEV, PERC ENDO
0DLN4ZZ	OCCLUSION OF SIGMOID COLON, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLN7DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, VIA OPENING
0DLN7ZZ	OCCLUSION OF SIGMOID COLON, VIA OPENING
0DLN8DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUMINAL DEVICE, ENDO
0DLN8ZZ	OCCLUSION OF SIGMOID COLON, ENDO
0DQ80ZZ	REPAIR SMALL INTESTINE, OPEN APPROACH
0DQ83ZZ	REPAIR SMALL INTESTINE, PERCUTANEOUS APPROACH
0DQ84ZZ	REPAIR SMALL INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DQ87ZZ	REPAIR SMALL INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DQ88ZZ	REPAIR SMALL INTESTINE, ENDO
0DQE0ZZ	REPAIR LARGE INTESTINE, OPEN APPROACH
0DQE3ZZ	REPAIR LARGE INTESTINE, PERCUTANEOUS APPROACH
0DQE4ZZ	REPAIR LARGE INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH
0DQE7ZZ	REPAIR LARGE INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DQE8ZZ	REPAIR LARGE INTESTINE, ENDO
0DT80ZZ	RESECTION OF SMALL INTESTINE, OPEN APPROACH
0DT84ZZ	RESECTION OF SMALL INTESTINE, PERC ENDO APPROACH
0DT87ZZ	RESECTION OF SMALL INTESTINE, VIA OPENING
0DT88ZZ	RESECTION OF SMALL INTESTINE, ENDO
0DT90ZZ	RESECTION OF DUODENUM, OPEN APPROACH
0DT94ZZ	RESECTION OF DUODENUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DT97ZZ	RESECTION OF DUODENUM, VIA NATURAL OR ARTIFICIAL OPENING
0DT98ZZ	RESECTION OF DUODENUM, ENDO
0DTN0ZZ	RESECTION OF SIGMOID COLON, OPEN APPROACH
0DTP0ZZ	RESECTION OF RECTUM, OPEN APPROACH
0DY80Z0	TRANSPLANTATION OF SMALL INTESTINE, ALLOGEN, OPEN APPROACH
0DY80Z1	TRANSPLANTATION OF SMALL INTESTINE, SYNGENEIC, OPEN APPROACH
0DY80Z2	TRANSPLANTATION OF SMALL INTESTINE, ZOOPLAST, OPEN APPROACH
0DYE0Z0	TRANSPLANTATION OF LARGE INTESTINE, ALLOGEN, OPEN APPROACH
0DYE0Z1	TRANSPLANTATION OF LARGE INTESTINE, SYNGENEIC, OPEN APPROACH
0DYE0Z2	TRANSPLANTATION OF LARGE INTESTINE, ZOOPLAST, OPEN APPROACH
0FB00ZZ	EXCISION OF LIVER, OPEN APPROACH
0FB03ZZ	EXCISION OF LIVER, PERCUTANEOUS APPROACH
0FB04ZZ	EXCISION OF LIVER, PERCUTANEOUS ENDOSCOPIC APPROACH
0FB10ZZ	EXCISION OF RIGHT LOBE LIVER, OPEN APPROACH
0FB13ZZ	EXCISION OF RIGHT LOBE LIVER, PERCUTANEOUS APPROACH
0FB14ZZ	EXCISION OF RIGHT LOBE LIVER, PERC ENDO APPROACH
0FB20ZZ	EXCISION OF LEFT LOBE LIVER, OPEN APPROACH
0FB23ZZ	EXCISION OF LEFT LOBE LIVER, PERCUTANEOUS APPROACH
0FB24ZZ	EXCISION OF LEFT LOBE LIVER, PERC ENDO APPROACH
0FBG0ZZ	EXCISION OF PANCREAS, OPEN APPROACH
0FBG3ZZ	EXCISION OF PANCREAS, PERCUTANEOUS APPROACH
0FBG4ZZ	EXCISION OF PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FSG0ZZ	REPOSITION PANCREAS, OPEN APPROACH
0FSG4ZZ	REPOSITION PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FT00ZZ	RESECTION OF LIVER, OPEN APPROACH
0FT04ZZ	RESECTION OF LIVER, PERCUTANEOUS ENDOSCOPIC APPROACH
0FT10ZZ	RESECTION OF RIGHT LOBE LIVER, OPEN APPROACH
0FT14ZZ	RESECTION OF RIGHT LOBE LIVER, PERC ENDO APPROACH
0FT20ZZ	RESECTION OF LEFT LOBE LIVER, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0FT24ZZ	RESECTION OF LEFT LOBE LIVER, PERC ENDO APPROACH
0FTG0ZZ	RESECTION OF PANCREAS, OPEN APPROACH
0FTG4ZZ	RESECTION OF PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FY00Z0	TRANSPLANTATION OF LIVER, ALLOGENEIC, OPEN APPROACH
0FY00Z1	TRANSPLANTATION OF LIVER, SYNGENEIC, OPEN APPROACH
0FY00Z2	TRANSPLANTATION OF LIVER, ZOOPLASTIC, OPEN APPROACH
0FYG0Z0	TRANSPLANTATION OF PANCREAS, ALLOGENEIC, OPEN APPROACH
0FYG0Z1	TRANSPLANTATION OF PANCREAS, SYNGENEIC, OPEN APPROACH
0FYG0Z2	TRANSPLANTATION OF PANCREAS, ZOOPLASTIC, OPEN APPROACH
5A02116	ASSIST WITH CARDIAC OUTPUT USING OTHER PUMP, INTERMITTENT
5A02216	ASSISTANCE WITH CARDIAC OUTPUT USING OTHER PUMP, CONTINUOUS
0TTB0ZZ	RESECTION OF BLADDER, OPEN APPROACH
0TTD0ZZ	RESECTION OF URETHRA, OPEN APPROACH
0UT40ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, OPEN APPROACH
0UT44ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UT47ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, VIA NATURAL OR ARTIFICIAL OPENING
0UT48ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0UT70ZZ	RESECTION OF BILATERAL FALLOPIAN TUBES, OPEN APPROACH
0WY20Z0	TRANSPLANTATION OF FACE, ALLOGENEIC, OPEN APPROACH
0WY20Z1	TRANSPLANTATION OF FACE, SYNGENEIC, OPEN APPROACH
0XYJ0Z0	TRANSPLANTATION OF RIGHT HAND, ALLOGENEIC, OPEN APPROACH
0XYJ0Z1	TRANSPLANTATION OF RIGHT HAND, SYNGENEIC, OPEN APPROACH
0XYK0Z0	TRANSPLANTATION OF LEFT HAND, ALLOGENEIC, OPEN APPROACH
0XYK0Z1	TRANSPLANTATION OF LEFT HAND, SYNGENEIC, OPEN APPROACH

October 2015 Update

For dates of service on or after **October 1, 2015,** the following ICD-10-PCS codes require prior authorization from KEPRO. For dates of service on or after October 1, 2016, refer to the October 2016 Update included in this section.

ICD-10 CODE	DESCRIPTION
02HA0QZ	INSERTION OF IMPLANT HEART ASSIST INTO HEART, OPEN APPROACH
02HA0RS	INSERT OF BIVENT EXT HEART ASSIST INTO HEART, OPEN APPROACH
02HA0RZ	INSERTION OF EXT HEART ASSIST INTO HEART, OPEN APPROACH
02HA3QZ	INSERTION OF IMPLANT HEART ASSIST INTO HEART, PERC APPROACH
02HA3RS	INSERT OF BIVENT EXT HEART ASSIST INTO HEART, PERC APPROACH
02HA3RZ	INSERTION OF EXT HEART ASSIST INTO HEART, PERC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
02HA4QZ	INSERT IMPLANT HEART ASSIST IN HEART, PERC ENDO
02HA4RS	INSERT BIVENT EXT HEART ASSIST IN HEART, PERC ENDO
02HA4RZ	INSERTION OF EXT HEART ASSIST INTO HEART, PERC ENDO APPROACH
02PA0RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, OPEN APPROACH
02PA3RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, PERC APPROACH
02PA4RZ	REMOVAL OF EXT HEART ASSIST FROM HEART, PERC ENDO APPROACH
02YA0Z0	TRANSPLANTATION OF HEART, ALLOGENEIC, OPEN APPROACH
02YA0Z1	TRANSPLANTATION OF HEART, SYNGENEIC, OPEN APPROACH
02YA0Z2	TRANSPLANTATION OF HEART, ZOOPLASTIC, OPEN APPROACH
0BYC0Z0	TRANSPLANTATION OF R UP LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYC0Z1	TRANSPLANTATION OF R UP LUNG LOBE, SYNGEN, OPEN APPROACH
0BYC0Z2	TRANSPLANTATION OF R UP LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYD0Z0	TRANSPLANTATION OF R MID LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYD0Z1	TRANSPLANTATION OF R MID LUNG LOBE, SYNGEN, OPEN APPROACH
0BYD0Z2	TRANSPLANTATION OF R MID LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYF0Z0	TRANSPLANTATION OF R LOW LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYF0Z1	TRANSPLANTATION OF R LOW LUNG LOBE, SYNGEN, OPEN APPROACH
0BYF0Z2	TRANSPLANTATION OF R LOW LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYG0Z0	TRANSPLANTATION OF L UP LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYG0Z1	TRANSPLANTATION OF L UP LUNG LOBE, SYNGEN, OPEN APPROACH
0BYG0Z2	TRANSPLANTATION OF L UP LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYH0Z0	TRANSPLANTATION OF LUNG LINGULA, ALLOGENEIC, OPEN APPROACH
0BYH0Z1	TRANSPLANTATION OF LUNG LINGULA, SYNGENEIC, OPEN APPROACH
0BYH0Z2	TRANSPLANTATION OF LUNG LINGULA, ZOOPLASTIC, OPEN APPROACH
0BYJ0Z0	TRANSPLANTATION OF L LOW LUNG LOBE, ALLOGEN, OPEN APPROACH
0BYJ0Z1	TRANSPLANTATION OF L LOW LUNG LOBE, SYNGEN, OPEN APPROACH
0BYJ0Z2	TRANSPLANTATION OF L LOW LUNG LOBE, ZOOPLAST, OPEN APPROACH
0BYK0Z0	TRANSPLANTATION OF RIGHT LUNG, ALLOGENEIC, OPEN APPROACH
0BYK0Z1	TRANSPLANTATION OF RIGHT LUNG, SYNGENEIC, OPEN APPROACH
0BYK0Z2	TRANSPLANTATION OF RIGHT LUNG, ZOOPLASTIC, OPEN APPROACH
0BYL0Z0	TRANSPLANTATION OF LEFT LUNG, ALLOGENEIC, OPEN APPROACH
0BYL0Z1	TRANSPLANTATION OF LEFT LUNG, SYNGENEIC, OPEN APPROACH
0BYL0Z2	TRANSPLANTATION OF LEFT LUNG, ZOOPLASTIC, OPEN APPROACH
0BYM0Z0	TRANSPLANTATION OF BILATERAL LUNGS, ALLOGEN, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0BYM0Z1	TRANSPLANTATION OF BILATERAL LUNGS, SYNGENEIC, OPEN APPROACH
0BYM0Z2	TRANSPLANTATION OF BILATERAL LUNGS, ZOOPLAST, OPEN APPROACH
0DL80CZ	OCCLUSION OF SMALL INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DL80DZ	OCCLUSION OF SMALL INTEST WITH INTRALUM DEV, OPEN APPROACH
0DL80ZZ	OCCLUSION OF SMALL INTESTINE, OPEN APPROACH
0DL83CZ	OCCLUSION OF SMALL INTEST WITH EXTRALUM DEV, PERC APPROACH
0DL83DZ	OCCLUSION OF SMALL INTEST WITH INTRALUM DEV, PERC APPROACH
0DL83ZZ	OCCLUSION OF SMALL INTESTINE, PERCUTANEOUS APPROACH
0DL84CZ	OCCLUSION SMALL INTEST W EXTRALUM DEV, PERC ENDO
0DL84DZ	OCCLUSION SMALL INTEST W INTRALUM DEV, PERC ENDO
0DL84ZZ	OCCLUSION OF SMALL INTESTINE, PERC ENDO APPROACH
0DL87DZ	OCCLUSION OF SMALL INTESTINE WITH INTRALUM DEV, VIA OPENING
0DL87ZZ	OCCLUSION OF SMALL INTESTINE, VIA OPENING
0DL88DZ	OCCLUSION OF SMALL INTESTINE WITH INTRALUMINAL DEVICE, ENDO
0DL88ZZ	OCCLUSION OF SMALL INTESTINE, ENDO
0DL90CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, OPEN APPROACH
0DL90DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, OPEN APPROACH
0DL90ZZ	OCCLUSION OF DUODENUM, OPEN APPROACH
0DL93CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, PERC APPROACH
0DL93DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, PERC APPROACH
0DL93ZZ	OCCLUSION OF DUODENUM, PERCUTANEOUS APPROACH
0DL94CZ	OCCLUSION OF DUODENUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DL94DZ	OCCLUSION OF DUODENUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DL94ZZ	OCCLUSION OF DUODENUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DL97DZ	OCCLUSION OF DUODENUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DL97ZZ	OCCLUSION OF DUODENUM, VIA NATURAL OR ARTIFICIAL OPENING
0DL98DZ	OCCLUSION OF DUODENUM WITH INTRALUMINAL DEVICE, ENDO
0DL98ZZ	OCCLUSION OF DUODENUM, ENDO
0DLA0CZ	OCCLUSION OF JEJUNUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLA0DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, OPEN APPROACH
0DLA0ZZ	OCCLUSION OF JEJUNUM, OPEN APPROACH
0DLA3CZ	OCCLUSION OF JEJUNUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLA3DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, PERC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLA3ZZ	OCCLUSION OF JEJUNUM, PERCUTANEOUS APPROACH
0DLA4CZ	OCCLUSION OF JEJUNUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLA4DZ	OCCLUSION OF JEJUNUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLA4ZZ	OCCLUSION OF JEJUNUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLA7DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLA7ZZ	OCCLUSION OF JEJUNUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLA8DZ	OCCLUSION OF JEJUNUM WITH INTRALUMINAL DEVICE, ENDO
0DLA8ZZ	OCCLUSION OF JEJUNUM, ENDO
0DLB0CZ	OCCLUSION OF ILEUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLB0DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, OPEN APPROACH
0DLB0ZZ	OCCLUSION OF ILEUM, OPEN APPROACH
0DLB3CZ	OCCLUSION OF ILEUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLB3DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, PERC APPROACH
0DLB3ZZ	OCCLUSION OF ILEUM, PERCUTANEOUS APPROACH
0DLB4CZ	OCCLUSION OF ILEUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLB4DZ	OCCLUSION OF ILEUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLB4ZZ	OCCLUSION OF ILEUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLB7DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLB7ZZ	OCCLUSION OF ILEUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLB8DZ	OCCLUSION OF ILEUM WITH INTRALUMINAL DEVICE, ENDO
0DLB8ZZ	OCCLUSION OF ILEUM, ENDO
0DLC0CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, OPEN
0DLC0DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, OPEN
0DLC0ZZ	OCCLUSION OF ILEOCECAL VALVE, OPEN APPROACH
0DLC3CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, PERC
0DLC3DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, PERC
0DLC3ZZ	OCCLUSION OF ILEOCECAL VALVE, PERCUTANEOUS APPROACH
0DLC4CZ	OCCLUSION ILEOCECAL VALVE W EXTRALUM DEV, PERC ENDO
0DLC4DZ	OCCLUSION ILEOCECAL VALVE W INTRALUM DEV, PERC ENDO
0DLC4ZZ	OCCLUSION OF ILEOCECAL VALVE, PERC ENDO APPROACH
0DLC7DZ	OCCLUSION OF ILEOCECAL VALVE WITH INTRALUM DEV, VIA OPENING
0DLC7ZZ	OCCLUSION OF ILEOCECAL VALVE, VIA OPENING
0DLC8DZ	OCCLUSION OF ILEOCECAL VALVE WITH INTRALUMINAL DEVICE, ENDO
0DLC8ZZ	OCCLUSION OF ILEOCECAL VALVE, ENDO
0DLE0CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLE0DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLE0ZZ	OCCLUSION OF LARGE INTESTINE, OPEN APPROACH
0DLE3CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, PERC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLE3DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLE3ZZ	OCCLUSION OF LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLE4CZ	OCCLUSION OF LG INTEST WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLE4DZ	OCCLUSION OF LG INTEST WITH INTRALUM DEV, PERC ENDO APPROACH
0DLE4ZZ	OCCLUSION OF LARGE INTESTINE, PERC ENDO APPROACH
0DLE7DZ	OCCLUSION OF LARGE INTESTINE WITH INTRALUM DEV, VIA OPENING
0DLE7ZZ	OCCLUSION OF LARGE INTESTINE, VIA OPENING
0DLE8DZ	OCCLUSION OF LARGE INTESTINE WITH INTRALUMINAL DEVICE, ENDO
0DLE8ZZ	OCCLUSION OF LARGE INTESTINE, ENDO
0DLF0CZ	OCCLUSION OF R LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLF0DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLF0ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, OPEN APPROACH
0DLF3CZ	OCCLUSION OF R LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLF3DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLF3ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLF4CZ	OCCLUSION R LG INTEST W EXTRALUM DEV, PERC ENDO
0DLF4DZ	OCCLUSION R LG INTEST W INTRALUM DEV, PERC ENDO
0DLF4ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, PERC ENDO APPROACH
0DLF7DZ	OCCLUSION OF R LG INTEST WITH INTRALUM DEV, VIA OPENING
0DLF7ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, VIA OPENING
0DLF8DZ	OCCLUSION OF RIGHT LARGE INTESTINE WITH INTRALUM DEV, ENDO
0DLF8ZZ	OCCLUSION OF RIGHT LARGE INTESTINE, ENDO
0DLG0CZ	OCCLUSION OF L LG INTEST WITH EXTRALUM DEV, OPEN APPROACH
0DLG0DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, OPEN APPROACH
0DLG0ZZ	OCCLUSION OF LEFT LARGE INTESTINE, OPEN APPROACH
0DLG3CZ	OCCLUSION OF L LG INTEST WITH EXTRALUM DEV, PERC APPROACH
0DLG3DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, PERC APPROACH
0DLG3ZZ	OCCLUSION OF LEFT LARGE INTESTINE, PERCUTANEOUS APPROACH
0DLG4CZ	OCCLUSION L LG INTEST W EXTRALUM DEV, PERC ENDO
0DLG4DZ	OCCLUSION L LG INTEST W INTRALUM DEV, PERC ENDO
0DLG4ZZ	OCCLUSION OF LEFT LARGE INTESTINE, PERC ENDO APPROACH
0DLG7DZ	OCCLUSION OF L LG INTEST WITH INTRALUM DEV, VIA OPENING
0DLG7ZZ	OCCLUSION OF LEFT LARGE INTESTINE, VIA OPENING
0DLG8DZ	OCCLUSION OF LEFT LARGE INTESTINE WITH INTRALUM DEV, ENDO
0DLG8ZZ	OCCLUSION OF LEFT LARGE INTESTINE, ENDO
0DLH0CZ	OCCLUSION OF CECUM WITH EXTRALUMINAL DEVICE, OPEN APPROACH
0DLH0DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLH0ZZ	OCCLUSION OF CECUM, OPEN APPROACH
0DLH3CZ	OCCLUSION OF CECUM WITH EXTRALUMINAL DEVICE, PERC APPROACH
0DLH3DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, PERC APPROACH
0DLH3ZZ	OCCLUSION OF CECUM, PERCUTANEOUS APPROACH
0DLH4CZ	OCCLUSION OF CECUM WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLH4DZ	OCCLUSION OF CECUM WITH INTRALUM DEV, PERC ENDO APPROACH
0DLH4ZZ	OCCLUSION OF CECUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLH7DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, VIA OPENING
0DLH7ZZ	OCCLUSION OF CECUM, VIA NATURAL OR ARTIFICIAL OPENING
0DLH8DZ	OCCLUSION OF CECUM WITH INTRALUMINAL DEVICE, ENDO
0DLH8ZZ	OCCLUSION OF CECUM, ENDO
0DLK0CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLK0DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, OPEN APPROACH
0DLK0ZZ	OCCLUSION OF ASCENDING COLON, OPEN APPROACH
0DLK3CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, PERC APPROACH
0DLK3DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, PERC APPROACH
0DLK3ZZ	OCCLUSION OF ASCENDING COLON, PERCUTANEOUS APPROACH
0DLK4CZ	OCCLUSION OF ASC COLON WITH EXTRALUM DEV, PERC ENDO APPROACH
0DLK4DZ	OCCLUSION OF ASC COLON WITH INTRALUM DEV, PERC ENDO APPROACH
0DLK4ZZ	OCCLUSION OF ASCENDING COLON, PERC ENDO APPROACH
0DLK7DZ	OCCLUSION OF ASCENDING COLON WITH INTRALUM DEV, VIA OPENING
0DLK7ZZ	OCCLUSION OF ASCENDING COLON, VIA OPENING
0DLK8DZ	OCCLUSION OF ASCENDING COLON WITH INTRALUMINAL DEVICE, ENDO
0DLK8ZZ	OCCLUSION OF ASCENDING COLON, ENDO
0DLL0CZ	OCCLUSION OF TRANS COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLL0DZ	OCCLUSION OF TRANS COLON WITH INTRALUM DEV, OPEN APPROACH
0DLL0ZZ	OCCLUSION OF TRANSVERSE COLON, OPEN APPROACH
0DLL3CZ	OCCLUSION OF TRANS COLON WITH EXTRALUM DEV, PERC APPROACH
0DLL3DZ	OCCLUSION OF TRANS COLON WITH INTRALUM DEV, PERC APPROACH
0DLL3ZZ	OCCLUSION OF TRANSVERSE COLON, PERCUTANEOUS APPROACH
0DLL4CZ	OCCLUSION TRANS COLON W EXTRALUM DEV, PERC ENDO
0DLL4DZ	OCCLUSION TRANS COLON W INTRALUM DEV, PERC ENDO
0DLL4ZZ	OCCLUSION OF TRANSVERSE COLON, PERC ENDO APPROACH
0DLL7DZ	OCCLUSION OF TRANSVERSE COLON WITH INTRALUM DEV, VIA OPENING
0DLL7ZZ	OCCLUSION OF TRANSVERSE COLON, VIA OPENING

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DLL8DZ	OCCLUSION OF TRANSVERSE COLON WITH INTRALUMINAL DEVICE, ENDO
0DLL8ZZ	OCCLUSION OF TRANSVERSE COLON, ENDO
0DLM0CZ	OCCLUSION OF DESCEND COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLM0DZ	OCCLUSION OF DESCEND COLON WITH INTRALUM DEV, OPEN APPROACH
0DLM0ZZ	OCCLUSION OF DESCENDING COLON, OPEN APPROACH
0DLM3CZ	OCCLUSION OF DESCEND COLON WITH EXTRALUM DEV, PERC APPROACH
0DLM3DZ	OCCLUSION OF DESCEND COLON WITH INTRALUM DEV, PERC APPROACH
0DLM3ZZ	OCCLUSION OF DESCENDING COLON, PERCUTANEOUS APPROACH
0DLM4CZ	OCCLUSION DESCEND COLON W EXTRALUM DEV, PERC ENDO
0DLM4DZ	OCCLUSION DESCEND COLON W INTRALUM DEV, PERC ENDO
0DLM4ZZ	OCCLUSION OF DESCENDING COLON, PERC ENDO APPROACH
0DLM7DZ	OCCLUSION OF DESCENDING COLON WITH INTRALUM DEV, VIA OPENING
0DLM7ZZ	OCCLUSION OF DESCENDING COLON, VIA OPENING
0DLM8DZ	OCCLUSION OF DESCENDING COLON WITH INTRALUMINAL DEVICE, ENDO
0DLM8ZZ	OCCLUSION OF DESCENDING COLON, ENDO
0DLN0CZ	OCCLUSION OF SIGMOID COLON WITH EXTRALUM DEV, OPEN APPROACH
0DLN0DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, OPEN APPROACH
0DLN0ZZ	OCCLUSION OF SIGMOID COLON, OPEN APPROACH
0DLN3CZ	OCCLUSION OF SIGMOID COLON WITH EXTRALUM DEV, PERC APPROACH
0DLN3DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, PERC APPROACH
0DLN3ZZ	OCCLUSION OF SIGMOID COLON, PERCUTANEOUS APPROACH
0DLN4CZ	OCCLUSION SIGMOID COLON W EXTRALUM DEV, PERC ENDO
0DLN4DZ	OCCLUSION SIGMOID COLON W INTRALUM DEV, PERC ENDO
0DLN4ZZ	OCCLUSION OF SIGMOID COLON, PERCUTANEOUS ENDOSCOPIC APPROACH
0DLN7DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUM DEV, VIA OPENING
0DLN7ZZ	OCCLUSION OF SIGMOID COLON, VIA OPENING
0DLN8DZ	OCCLUSION OF SIGMOID COLON WITH INTRALUMINAL DEVICE, ENDO
0DLN8ZZ	OCCLUSION OF SIGMOID COLON, ENDO
0DQ80ZZ	REPAIR SMALL INTESTINE, OPEN APPROACH
0DQ83ZZ	REPAIR SMALL INTESTINE, PERCUTANEOUS APPROACH
0DQ84ZZ	REPAIR SMALL INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0DQ87ZZ	REPAIR SMALL INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DQ88ZZ	REPAIR SMALL INTESTINE, ENDO
0DQE0ZZ	REPAIR LARGE INTESTINE, OPEN APPROACH
0DQE3ZZ	REPAIR LARGE INTESTINE, PERCUTANEOUS APPROACH
0DQE4ZZ	REPAIR LARGE INTESTINE, PERCUTANEOUS ENDOSCOPIC APPROACH
0DQE7ZZ	REPAIR LARGE INTESTINE, VIA NATURAL OR ARTIFICIAL OPENING
0DQE8ZZ	REPAIR LARGE INTESTINE, ENDO
0DT80ZZ	RESECTION OF SMALL INTESTINE, OPEN APPROACH
0DT84ZZ	RESECTION OF SMALL INTESTINE, PERC ENDO APPROACH
0DT87ZZ	RESECTION OF SMALL INTESTINE, VIA OPENING
0DT88ZZ	RESECTION OF SMALL INTESTINE, ENDO
0DT90ZZ	RESECTION OF DUODENUM, OPEN APPROACH
0DT94ZZ	RESECTION OF DUODENUM, PERCUTANEOUS ENDOSCOPIC APPROACH
0DT97ZZ	RESECTION OF DUODENUM, VIA NATURAL OR ARTIFICIAL OPENING
0DT98ZZ	RESECTION OF DUODENUM, ENDO
0DTN0ZZ	RESECTION OF SIGMOID COLON, OPEN APPROACH
0DTP0ZZ	RESECTION OF RECTUM, OPEN APPROACH
0DY80Z0	TRANSPLANTATION OF SMALL INTESTINE, ALLOGEN, OPEN APPROACH
0DY80Z1	TRANSPLANTATION OF SMALL INTESTINE, SYNGENEIC, OPEN APPROACH
0DY80Z2	TRANSPLANTATION OF SMALL INTESTINE, ZOOPLAST, OPEN APPROACH
0DYE0Z0	TRANSPLANTATION OF LARGE INTESTINE, ALLOGEN, OPEN APPROACH
0DYE0Z1	TRANSPLANTATION OF LARGE INTESTINE, SYNGENEIC, OPEN APPROACH
0DYE0Z2	TRANSPLANTATION OF LARGE INTESTINE, ZOOPLAST, OPEN APPROACH
0FB00ZZ	EXCISION OF LIVER, OPEN APPROACH
0FB03ZZ	EXCISION OF LIVER, PERCUTANEOUS APPROACH
0FB04ZZ	EXCISION OF LIVER, PERCUTANEOUS ENDOSCOPIC APPROACH
0FB10ZZ	EXCISION OF RIGHT LOBE LIVER, OPEN APPROACH
0FB13ZZ	EXCISION OF RIGHT LOBE LIVER, PERCUTANEOUS APPROACH
0FB14ZZ	EXCISION OF RIGHT LOBE LIVER, PERC ENDO APPROACH
0FB20ZZ	EXCISION OF LEFT LOBE LIVER, OPEN APPROACH
0FB23ZZ	EXCISION OF LEFT LOBE LIVER, PERCUTANEOUS APPROACH
0FB24ZZ	EXCISION OF LEFT LOBE LIVER, PERC ENDO APPROACH
0FBG0ZZ	EXCISION OF PANCREAS, OPEN APPROACH
0FBG3ZZ	EXCISION OF PANCREAS, PERCUTANEOUS APPROACH
0FBG4ZZ	EXCISION OF PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FSG0ZZ	REPOSITION PANCREAS, OPEN APPROACH
0FSG4ZZ	REPOSITION PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

ICD-10 CODE	DESCRIPTION
0FT00ZZ	RESECTION OF LIVER, OPEN APPROACH
0FT04ZZ	RESECTION OF LIVER, PERCUTANEOUS ENDOSCOPIC APPROACH
0FT10ZZ	RESECTION OF RIGHT LOBE LIVER, OPEN APPROACH
0FT14ZZ	RESECTION OF RIGHT LOBE LIVER, PERC ENDO APPROACH
0FT20ZZ	RESECTION OF LEFT LOBE LIVER, OPEN APPROACH
0FT24ZZ	RESECTION OF LEFT LOBE LIVER, PERC ENDO APPROACH
0FTG0ZZ	RESECTION OF PANCREAS, OPEN APPROACH
0FTG4ZZ	RESECTION OF PANCREAS, PERCUTANEOUS ENDOSCOPIC APPROACH
0FY00Z0	TRANSPLANTATION OF LIVER, ALLOGENEIC, OPEN APPROACH
0FY00Z1	TRANSPLANTATION OF LIVER, SYNGENEIC, OPEN APPROACH
0FY00Z2	TRANSPLANTATION OF LIVER, ZOOPLASTIC, OPEN APPROACH
0FYG0Z0	TRANSPLANTATION OF PANCREAS, ALLOGENEIC, OPEN APPROACH
0FYG0Z1	TRANSPLANTATION OF PANCREAS, SYNGENEIC, OPEN APPROACH
0FYG0Z2	TRANSPLANTATION OF PANCREAS, ZOOPLASTIC, OPEN APPROACH
5A02116	ASSIST WITH CARDIAC OUTPUT USING OTHER PUMP, INTERMITTENT
5A02216	ASSISTANCE WITH CARDIAC OUTPUT USING OTHER PUMP, CONTINUOUS
0TTB0ZZ	RESECTION OF BLADDER, OPEN APPROACH
0TTD0ZZ	RESECTION OF URETHRA, OPEN APPROACH
0UT20ZZ	RESECTION OF BILATERAL OVARIES, OPEN APPROACH
0UT40ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, OPEN APPROACH
0UT44ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UT47ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, VIA NATURAL OR ARTIFICIAL OPENING
0UT48ZZ	RESECTION OF UTERINE SUPPORTING STRUCTURE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0UT70ZZ	RESECTION OF BILATERAL FALLOPIAN TUBES, OPEN APPROACH

PT, OT, AND SPEECH THERAPY CPT CODES

Please submit a prior authorization requests to the QIO (KEPRO) for the following CPT codes:

CODE	DESCRIPTION
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER
92508	GROUP TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER
92521	EVALUATION OF SPEECH FLUENCY (E.G., STUTTERING, CLUTTERING)
92522	EVALUATION OF SPEECH SOUND PRODUCTION (E.G., ARTICULATION, PHONOLOGICAL PROCESS, APRAXIA, DYSARTHRIA)

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
92523	EVALUATION OF SPEECH SOUND PRODUCTION (E.G., ARTICULATION, PHONOLOGICAL PROCESS, APRAXIA, DYSARTHRIA); **WITH** EVALUATION OF LANGUAGE COMPREHENSION AND EXPRESSION (E.G., RECEPTIVE AND EXPRESSIVE LANGUAGE)
92524	BEHAVIORAL AND QUALITATIVE ANALYSIS OF VOICE AND RESONANCE
92607	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; FIRST HOUR
92608	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; EACH ADDITIONAL 30 MINUTES
92609	THERAPEUTIC SERVICES FOR THE USE OF SPEECH-GENERATING DEVICE, INCLUDING PROGRAMMING AND MODIFICATION
92610	EVALUATION OF ORAL AND PHARYNGEAL SWALLOWING FUNCTION
97012	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL
97016	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; PARAFFIN BATH
97022	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (EG, MICROWAVE)
97026	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF ELECTRICAL STIMULATION TO 1 OR MORE AREAS, EACH 15 MINUTES
97033	APPLICATION OF MEDICATION THROUGH SKIN USING ELECTRICAL CURRENT, EACH 15 MINUTES
97034	THERAPEUTIC HOT AND COLD BATHS TO 1 OR MORE AREAS, EACH 15 MINUTES
97035	APPLICATION OF ULTRASOUND TO 1 OR MORE AREAS, EACH 15 MINUTES
97036	PHYSICAL THERAPY TREATMENT TO 1 OR MORE AREAS, HUBBARD TANK, EACH 15 MINUTES
97110	THERAPEUTIC EXERCISE TO DEVELOP STRENGTH, ENDURANCE, RANGE OF MOTION, AND FLEXIBILITY, EACH 15 MINUTES
97112	THERAPEUTIC PROCEDURE TO RE-EDUCATE BRAIN-TO-NERVE-TO-MUSCLE FUNCTION, EACH 15 MINUTES
97113	WATER POOL THERAPY WITH THERAPEUTIC EXERCISES TO 1 OR MORE AREAS, EACH 15 MINUTES
97116	WALKING TRAINING TO 1 OR MORE AREAS, EACH 15 MINUTES
97124	THERAPEUTIC MASSAGE TO 1 OR MORE AREAS, EACH 15 MINUTES
97127	ONE-ON-ONE THERAPEUTIC INTERVENTIONS FOCUSED ON THOUGHT PROCESSING AND STRATEGIES TO MANAGE ACTIVITIES

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
97140	MANUAL (PHYSICAL) THERAPY TECHNIQUES TO 1 OR MORE REGIONS, EACH 15 MINUTES
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97161	EVALUATION OF PHYSICAL THERAPY, TYPICALLY 20 MINUTES
97162	EVALUATION OF PHYSICAL THERAPY, TYPICALLY 30 MINUTES
97163	EVALUATION OF PHYSICAL THERAPY, TYPICALLY 45 MINUTES
97164	RE-EVALUATION OF PHYSICAL THERAPY, TYPICALLY 20 MINUTES
97165	EVALUATION OF OCCUPATIONAL THERAPY, TYPICALLY 30 MINUTES
97166	EVALUATION OF OCCUPATIONAL THERAPY, TYPICALLY 45 MINUTES
97167	EVALUATION OF OCCUPATIONAL THERAPY ESTABLISHED PLAN OF CARE, TYPICALLY 60 MINUTES
97168	RE-EVALUATION OF OCCUPATIONAL THERAPY ESTABLISHED PLAN OF CARE, TYPICALLY 30 MINUTES
97530	THERAPEUTIC ACTIVITIES TO IMPROVE FUNCTION, WITH ONE-ON-ONE CONTACT BETWEEN PATIENT AND PROVIDER, EACH 15 MINUTES
97533	SENSORY TECHNIQUE TO ENHANCE PROCESSING AND ADAPTATION TO ENVIRONMENTAL DEMANDS, EACH 15 MINUTES
97535	SELF-CARE OR HOME MANAGEMENT TRAINING, EACH 15 MINUTES
97537	COMMUNITY OR WORK REINTEGRATION TRAINING, EACH 15 MINUTES
97542	WHEELCHAIR MANAGEMENT, EACH 15 MINUTES
97597	DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL AND FORCEPS), OPEN WOUND, (EG, FIBRIN, DEVITALIZED EPIDERMIS AND/OR DERMIS, EXUDATE, DEBRIS, BIOFILM), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, USE OF A WHIRLPOOL, WHEN PERFORMED AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION, TOTAL WOUND(S) SURFACE AREA; FIRST 20 SQ CM OR LESS
97598	DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL AND FORCEPS), OPEN WOUND, (EG, FIBRIN, DEVITALIZED EPIDERMIS AND/OR DERMIS, EXUDATE, DEBRIS, BIOFILM), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, USE OF A WHIRLPOOL, WHEN PERFORMED AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION, TOTAL WOUND(S) SURFACE AREA; EACH ADDITIONAL 20 SQ CM, OR PART THEREOF
97605	NEGATIVE PRESSURE WOUND THERAPY, SURFACE AREA LESS THAN OR EQUAL TO 50 SQUARE CENTIMETERS, PER SESSION
97606	NEGATIVE PRESSURE WOUND THERAPY, SURFACE AREA GREATER THAN 50 SQUARE CENTIMETERS, PER SESSION
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT WITH REPORT, EACH 15 MINUTES
97755	ASSISTIVE TECHNOLOGY ASSESSMENT TO ENHANCE FUNCTIONAL PERFORMANCE, EACH 15 MINUTES

SECTION 4 BILLING CODES

BILLING CODES REQUIRING PRIOR AUTHORIZATION

CODE	DESCRIPTION
97760	TRAINING IN USE OF ORTHOTICS (SUPPORTS, BRACES, OR SPLINTS) FOR ARMS, LEGS AND/OR TRUNK, PER 15 MINUTES
97761	TRAINING IN USE OF PROSTHESIS FOR ARMS AND/OR LEGS, PER 15 MINUTES
97763	MANAGEMENT AND/OR TRAINING IN USE OF ORTHOTICS (SUPPORTS, BRACES, OR SPLINTS) FOR ARMS, LEGS, AND/OR TRUNK, PER 15 MINUTES

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

OUTPATIENT HOSPITAL SERVICES

The following CPT codes for outpatient hospital services require a review of support documentation by the QIO, KEPRO:

CODE	DESCRIPTION
21206	OSTEOTOMY, MAXILLA, SEGMENTAL (WASSMUND)
21208	OSTEOPLASTY,FACIAL BONES AUGMENT(IMPLANT
21209	OSTEOPLASTY,FACIAL BONES REDUCTION
21210	GRAFT BONE NASAL MAXI-MALAR(INC GRAF)
21215	GRAFT BONE MANDIBLE (INC OBTAIN GRAFT
21235	GRAFT EAR CART;AUTOG, TO NOSE OR EAR
21243	ARTHROPLASTY TMJWITH PROSTHETIC JOINT
21246	RECONSTRU MAND/MAXIL IMPLANT COMPLETE
21256	RECONSTR ORBIT W OSTEOTOMIES&BNEGRAFTS
21260	ORBIT HYPER CORR(PERIOR) EXCRAN APPROACH
21261	PERIOR OSTOMY FR HYPERT INTRA A EXTRACR
21263	ORBIT HYPER (PERIOB) WITH FOREHEA ADVANC
21267	ORBIT REPOS PERI OST UNILAT W GRFT EXTRC
21270	MALAR AUGMENT, PROSTHETIC MATERIAL
21275	SECNRY REVIS ORBITOCRAINIOFACL RECNSRUCT
21282	LATERAL CANTHOPEXY
21295	REDUCT MASSETER MUSCLE/BONE ESTRAORAL AP
21296	REDUCT MASSETER MUSCLE/BONE INTRAORAL AP
36592	COLLECT BLOOD FROM CNTRL/PERIPH CATH,NOS
36593	DECLOT THROMBOLYTIC AGNT OF VASCULAR DEV
55200	VASOTOMY CANNULI W/WO INCIS VAS UNI/BILA
55250	VASECTOMY UNI/BIL (SEP PRO) INC POSTOP SE
59200	INSERT CERVICAL DILATOR(EG.LAMINAR,PROST
59840	INDUCED ABORTION PER D&C
59841	INDUCE ABORT, DILATION & EVAC
59850	INDUCE ABORT, BY INJECT INCLD HOSP ADM, DV
59851	INDUCE ABORT, D&C &/OR EVACUATION

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
59852	INDUCED AB BY AMNIO INJ W HYSTEROTOMY
59855	INDUCE ABORT BY VAG SUPPOSIT INC HOS ADM
59856	INDUCE ABORT VAG SUPPOS HOSP ADM W/D&C
59857	INDUCE ABORT VAG SUPPOS HOSP ADM W/HYST
67912	CX LAGOPHTHALMOS, UP EYELID LID LOAD IMPL
74740	PHYSTOSALPINGOGRAPHY SUPERVIS/INTER

ICD-10-PCS SURGICAL CODES

October 2017 Update

For dates of service on or after **October 1, 2017**, the following ICD-10-PCS surgical codes require a review of support documentation by the QIO, KEPRO. For dates of service prior to October 1, 2017, refer to the October 2015 Update included in this section.

CODE	DESCRIPTION
10A07ZX	ABORTION OF PRODUCTS OF CONCEPTION, ABORTIFACIENT, VIA NATURAL OR ARTIFICIAL OPENING
10A08ZZ	ABORTION OF PRODUCTS OF CONCEPTION, ENDO
10A07ZW	ABORTION OF PRODUCTS OF CONCEPTION, LAMINARIA, VIA NATURAL OR ARTIFICIAL OPENING
10A00ZZ	ABORTION OF PRODUCTS OF CONCEPTION, OPEN APPROACH
10A03ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH
10A04ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS ENDOSCOPIC APPROACH
10A07ZZ	ABORTION OF PRODUCTS OF CONCEPTION, VIA OPENING
0D16879	BYPASS STOMACH TO DUODENUM WITH AUTOL SUB, ENDO
0D16079	BYPASS STOMACH TO DUODENUM WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0D168K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, ENDO
0D160K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, OPEN APPROACH
0D160J9	BYPASS STOMACH TO DUODENUM WITH SYNTH SUB, OPEN APPROACH
0D168J9	BYPASS STOMACH TO DUODENUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168Z9	BYPASS STOMACH TO DUODENUM, ENDO
0D160Z9	BYPASS STOMACH TO DUODENUM, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0D1687B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, ENDO
0D1607B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, OPEN APPROACH
0D168KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, ENDO
0D160KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, OPEN APPROACH
0D160JB	BYPASS STOMACH TO ILEUM WITH SYNTH SUB, OPEN APPROACH
0D168JB	BYPASS STOMACH TO ILEUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168ZB	BYPASS STOMACH TO ILEUM, ENDO
0D160ZB	BYPASS STOMACH TO ILEUM, OPEN APPROACH
0D1687A	BYPASS STOMACH TO JEJUNUM WITH AUTOL SUB, ENDO
0D1607A	BYPASS STOMACH TO JEJUNUM WITH AUTOL SUB, OPEN APPROACH
0D168KA	BYPASS STOMACH TO JEJUNUM WITH NONAUT SUB, ENDO
0D160KA	BYPASS STOMACH TO JEJUNUM WITH NONAUT SUB, OPEN APPROACH
0D160JA	BYPASS STOMACH TO JEJUNUM WITH SYNTH SUB, OPEN APPROACH
0D168JA	BYPASS STOMACH TO JEJUNUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168ZA	BYPASS STOMACH TO JEJUNUM, ENDO
0D160ZA	BYPASS STOMACH TO JEJUNUM, OPEN APPROACH
0D1607L	BYPASS STOMACH TO TRANS COLON WITH AUTOL SUB, OPEN APPROACH
0D160KL	BYPASS STOMACH TO TRANS COLON WITH NONAUT SUB, OPEN APPROACH
0D160JL	BYPASS STOMACH TO TRANS COLON WITH SYNTH SUB, OPEN APPROACH
0D1687L	BYPASS STOMACH TO TRANSVERSE COLON WITH AUTOL SUB, ENDO
0D168KL	BYPASS STOMACH TO TRANSVERSE COLON WITH NONAUT SUB, ENDO
0D168JL	BYPASS STOMACH TO TRANSVERSE COLON WITH SYNTH SUB, ENDO
0D168ZL	BYPASS STOMACH TO TRANSVERSE COLON, ENDO
0D160ZL	BYPASS STOMACH TO TRANSVERSE COLON, OPEN APPROACH
0VLQ0DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, OPEN
0VLQ3DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC
0VLQ4DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VLP4DZ	OCCLUSION L VAS DEFERENS W INTRALUM DEV, PERC ENDO
0UL70ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, OPEN APPROACH
0UL73ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS APPROACH
0UL74ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS ENDOSCOPIC APPROACH
0VLQ8DZ	OCCLUSION OF BILATERAL VAS DEFERENS WITH INTRALUMINAL DEVICE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VLP0DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLP3DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0UL60ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, OPEN APPROACH
0UL63ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0UL64ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0VLP8DZ	OCCLUSION OF LEFT VAS DEFERENS WITH INTRALUMINAL DEVICE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VLN0DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLN3DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0UL50ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, OPEN APPROACH
0UL53ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS APPROACH
0UL54ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0VLN8DZ	OCCLUSION OF RIGHT VAS DEFERENS WITH INTRALUMINAL DEVICE, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VLN4DZ	OCCLUSION R VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VNL0ZZ	RELEASE BILATERAL EPIDIDYMIS, OPEN APPROACH
0VNL4ZZ	RELEASE BILATERAL EPIDIDYMIS, PERC ENDO APPROACH
0VNL3ZZ	RELEASE BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNL8ZZ	RELEASE BILATERAL EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VNK0ZZ	RELEASE LEFT EPIDIDYMIS, OPEN APPROACH
0VNK3ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNK4ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNK8ZZ	RELEASE LEFT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0NNG0ZZ	RELEASE LEFT ETHMOID BONE, OPEN APPROACH
0NNG3ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNG4ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNJ0ZZ	RELEASE LEFT LACRIMAL BONE, OPEN APPROACH
0NNJ3ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNJ4ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNV0ZZ	RELEASE LEFT MANDIBLE, OPEN APPROACH
0NNV3ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS APPROACH
0NNV4ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNQ0ZZ	RELEASE LEFT ORBIT, OPEN APPROACH
0NNQ3ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS APPROACH
0NNQ4ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNL0ZZ	RELEASE LEFT PALATINE BONE, OPEN APPROACH
0NNL3ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS APPROACH
0NNL4ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0RND0ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0RND3ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH
0RND4ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNN0ZZ	RELEASE LEFT ZYGOMATIC BONE, OPEN APPROACH
0NNN3ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNN4ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNR0ZZ	RELEASE MAXILLA, OPEN APPROACH
0NNR3ZZ	RELEASE MAXILLA, PERCUTANEOUS APPROACH
0NNR4ZZ	RELEASE MAXILLA, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNJ0ZZ	RELEASE RIGHT EPIDIDYMIS, OPEN APPROACH
0VNJ3ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNJ4ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNJ8ZZ	RELEASE RIGHT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0NNF0ZZ	RELEASE RIGHT ETHMOID BONE, OPEN APPROACH
0NNF3ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNF4ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNH0ZZ	RELEASE RIGHT LACRIMAL BONE, OPEN APPROACH
0NNH3ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNH4ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNT0ZZ	RELEASE RIGHT MANDIBLE, OPEN APPROACH
0NNT3ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS APPROACH
0NNT4ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNP0ZZ	RELEASE RIGHT ORBIT, OPEN APPROACH
0NNP3ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS APPROACH
0NNP4ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNK0ZZ	RELEASE RIGHT PALATINE BONE, OPEN APPROACH
0NNK3ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NNK4ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0RNC0ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, OPEN APPROACH
0RNC3ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH
0RNC4ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNM0ZZ	RELEASE RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NNM3ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNM4ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNC0ZZ	RELEASE SPHENOID BONE, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0NNC3ZZ	RELEASE SPHENOID BONE, PERCUTANEOUS APPROACH
0NNC4ZZ	RELEASE SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQL0ZZ	REPAIR BILATERAL EPIDIDYMIS, OPEN APPROACH
0VQL3ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQL4ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQL8ZZ	REPAIR BILATERAL EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQH0ZZ	REPAIR BILATERAL SPERMATIC CORDS, OPEN APPROACH
0VQH4ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQH3ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS APPROACH
0VQH8ZZ	REPAIR BILATERAL SPERMATIC CORDS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQQ0ZZ	REPAIR BILATERAL VAS DEFERENS, OPEN APPROACH
0VQQ3ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS APPROACH
0VQQ4ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQQ8ZZ	REPAIR BILATERAL VAS DEFERENS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
00Q00ZZ	REPAIR BRAIN, OPEN APPROACH
00Q03ZZ	REPAIR BRAIN, PERCUTANEOUS APPROACH
00Q04ZZ	REPAIR BRAIN, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQXXZZ	REPAIR HYOID BONE, EXTERNAL APPROACH
0NQX0ZZ	REPAIR HYOID BONE, OPEN APPROACH
0NQX3ZZ	REPAIR HYOID BONE, PERCUTANEOUS APPROACH
0NQX4ZZ	REPAIR HYOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQK0ZZ	REPAIR LEFT EPIDIDYMIS, OPEN APPROACH
0VQK3ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQK4ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQK8ZZ	REPAIR LEFT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0NQGXZZ	REPAIR LEFT ETHMOID BONE, EXTERNAL APPROACH
0NQG0ZZ	REPAIR LEFT ETHMOID BONE, OPEN APPROACH
0NQG3ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQG4ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQJXZZ	REPAIR LEFT LACRIMAL BONE, EXTERNAL APPROACH
0NQJ0ZZ	REPAIR LEFT LACRIMAL BONE, OPEN APPROACH
0NQJ3ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQJ4ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQLXZZ	REPAIR LEFT PALATINE BONE, EXTERNAL APPROACH
0NQL0ZZ	REPAIR LEFT PALATINE BONE, OPEN APPROACH
0NQL3ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0NQL4ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQG0ZZ	REPAIR LEFT SPERMATIC CORD, OPEN APPROACH
0VQG3ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQG4ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQG8ZZ	REPAIR LEFT SPERMATIC CORD, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQP0ZZ	REPAIR LEFT VAS DEFERENS, OPEN APPROACH
0VQP3ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQP4ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQP8ZZ	REPAIR LEFT VAS DEFERENS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0NQNXZZ	REPAIR LEFT ZYGOMATIC BONE, EXTERNAL APPROACH
0NQN0ZZ	REPAIR LEFT ZYGOMATIC BONE, OPEN APPROACH
0NQN3ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQN4ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQJ0ZZ	REPAIR RIGHT EPIDIDYMIS, OPEN APPROACH
0VQJ3ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQJ4ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQJ8ZZ	REPAIR RIGHT EPIDIDYMIS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0NQFXZZ	REPAIR RIGHT ETHMOID BONE, EXTERNAL APPROACH
0NQF0ZZ	REPAIR RIGHT ETHMOID BONE, OPEN APPROACH
0NQF3ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQF4ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQHXZZ	REPAIR RIGHT LACRIMAL BONE, EXTERNAL APPROACH
0NQH0ZZ	REPAIR RIGHT LACRIMAL BONE, OPEN APPROACH
0NQH3ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQH4ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQKXZZ	REPAIR RIGHT PALATINE BONE, EXTERNAL APPROACH
0NQK0ZZ	REPAIR RIGHT PALATINE BONE, OPEN APPROACH
0NQK3ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NQK4ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQF0ZZ	REPAIR RIGHT SPERMATIC CORD, OPEN APPROACH
0VQF3ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQF4ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQF8ZZ	REPAIR RIGHT SPERMATIC CORD, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0VQN0ZZ	REPAIR RIGHT VAS DEFERENS, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0VQN3ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQN4ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQN8ZZ	REPAIR RIGHT VAS DEFERENS, VIA NATURAL OR ARTIFICIAL OPENING ENDOSCOPIC
0NQMXZZ	REPAIR RIGHT ZYGOMATIC BONE, EXTERNAL APPROACH
0NQM0ZZ	REPAIR RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NQM3ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQM4ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQCXZZ	REPAIR SPHENOID BONE, EXTERNAL APPROACH
0NQC0ZZ	REPAIR SPHENOID BONE, OPEN APPROACH
0NQC3ZZ	REPAIR SPHENOID BONE, PERCUTANEOUS APPROACH
0NQC4ZZ	REPAIR SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR07Z	REPLACEMENT OF MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR37Z	REPLACEMENT OF MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR47Z	REPLACEMENT OF MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR0KZ	REPLACEMENT OF MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR3KZ	REPLACEMENT OF MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR4KZ	REPLACEMENT OF MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR0JZ	REPLACEMENT OF MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NRR3JZ	REPLACEMENT OF MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR4JZ	REPLACEMENT OF MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
08SRXZZ	REPOSITION LEFT LOWER EYELID, EXTERNAL APPROACH
08SR0ZZ	REPOSITION LEFT LOWER EYELID, OPEN APPROACH
08SR3ZZ	REPOSITION LEFT LOWER EYELID, PERCUTANEOUS APPROACH
08SPXZZ	REPOSITION LEFT UPPER EYELID, EXTERNAL APPROACH
08SP0ZZ	REPOSITION LEFT UPPER EYELID, OPEN APPROACH
08SP3ZZ	REPOSITION LEFT UPPER EYELID, PERCUTANEOUS APPROACH
08SQXZZ	REPOSITION RIGHT LOWER EYELID, EXTERNAL APPROACH
08SQ0ZZ	REPOSITION RIGHT LOWER EYELID, OPEN APPROACH
08SQ3ZZ	REPOSITION RIGHT LOWER EYELID, PERCUTANEOUS APPROACH
08SNXZZ	REPOSITION RIGHT UPPER EYELID, EXTERNAL APPROACH
08SN0ZZ	REPOSITION RIGHT UPPER EYELID, OPEN APPROACH
08SN3ZZ	REPOSITION RIGHT UPPER EYELID, PERCUTANEOUS APPROACH
0NUR07Z	SUPPLEMENT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0NUR37Z	SUPPLEMENT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR47Z	SUPPLEMENT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR0KZ	SUPPLEMENT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUR3KZ	SUPPLEMENT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR4KZ	SUPPLEMENT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR0JZ	SUPPLEMENT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NUR3JZ	SUPPLEMENT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR4JZ	SUPPLEMENT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH

October 2015 Update

For dates of service on or after **October 1, 2015**, the following ICD-10-PCS surgical codes require a review of support documentation by the QIO, KEPRO. For dates of service on or after October 1, 2017, refer to the October 2017 Update included in this section.

CODE	DESCRIPTION
00Q00ZZ	REPAIR BRAIN, OPEN APPROACH
00Q03ZZ	REPAIR BRAIN, PERCUTANEOUS APPROACH
00Q04ZZ	REPAIR BRAIN, PERCUTANEOUS ENDOSCOPIC APPROACH
08SN0ZZ	REPOSITION RIGHT UPPER EYELID, OPEN APPROACH
08SN3ZZ	REPOSITION RIGHT UPPER EYELID, PERCUTANEOUS APPROACH
08SNXZZ	REPOSITION RIGHT UPPER EYELID, EXTERNAL APPROACH
08SP0ZZ	REPOSITION LEFT UPPER EYELID, OPEN APPROACH
08SP3ZZ	REPOSITION LEFT UPPER EYELID, PERCUTANEOUS APPROACH
08SPXZZ	REPOSITION LEFT UPPER EYELID, EXTERNAL APPROACH
08SQ0ZZ	REPOSITION RIGHT LOWER EYELID, OPEN APPROACH
08SQ3ZZ	REPOSITION RIGHT LOWER EYELID, PERCUTANEOUS APPROACH
08SQXZZ	REPOSITION RIGHT LOWER EYELID, EXTERNAL APPROACH
08SR0ZZ	REPOSITION LEFT LOWER EYELID, OPEN APPROACH
08SR3ZZ	REPOSITION LEFT LOWER EYELID, PERCUTANEOUS APPROACH
08SRXZZ	REPOSITION LEFT LOWER EYELID, EXTERNAL APPROACH
0D16079	BYPASS STOMACH TO DUODENUM WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0D1607A	BYPASS STOMACH TO JEJUNUM WITH AUTOL SUB, OPEN APPROACH
0D1607B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, OPEN APPROACH
0D1607L	BYPASS STOMACH TO TRANS COLON WITH AUTOL SUB, OPEN APPROACH
0D160J9	BYPASS STOMACH TO DUODENUM WITH SYNTH SUB, OPEN APPROACH
0D160JA	BYPASS STOMACH TO JEJUNUM WITH SYNTH SUB, OPEN APPROACH
0D160JB	BYPASS STOMACH TO ILEUM WITH SYNTH SUB, OPEN APPROACH
0D160JL	BYPASS STOMACH TO TRANS COLON WITH SYNTH SUB, OPEN APPROACH
0D160K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, OPEN APPROACH
0D160KA	BYPASS STOMACH TO JEJUNUM WITH NONAUT SUB, OPEN APPROACH
0D160KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, OPEN APPROACH
0D160KL	BYPASS STOMACH TO TRANS COLON WITH NONAUT SUB, OPEN APPROACH
0D160Z9	BYPASS STOMACH TO DUODENUM, OPEN APPROACH
0D160ZA	BYPASS STOMACH TO JEJUNUM, OPEN APPROACH
0D160ZB	BYPASS STOMACH TO ILEUM, OPEN APPROACH
0D160ZL	BYPASS STOMACH TO TRANSVERSE COLON, OPEN APPROACH
0D16879	BYPASS STOMACH TO DUODENUM WITH AUTOL SUB, ENDO
0D1687A	BYPASS STOMACH TO JEJUNUM WITH AUTOL SUB, ENDO
0D1687B	BYPASS STOMACH TO ILEUM WITH AUTOL SUB, ENDO
0D1687L	BYPASS STOMACH TO TRANSVERSE COLON WITH AUTOL SUB, ENDO
0D168J9	BYPASS STOMACH TO DUODENUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168JA	BYPASS STOMACH TO JEJUNUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168JB	BYPASS STOMACH TO ILEUM WITH SYNTHETIC SUBSTITUTE, ENDO
0D168JL	BYPASS STOMACH TO TRANSVERSE COLON WITH SYNTH SUB, ENDO
0D168K9	BYPASS STOMACH TO DUODENUM WITH NONAUT SUB, ENDO
0D168KA	BYPASS STOMACH TO JEJUNUM WITH NONAUT SUB, ENDO
0D168KB	BYPASS STOMACH TO ILEUM WITH NONAUT SUB, ENDO
0D168KL	BYPASS STOMACH TO TRANSVERSE COLON WITH NONAUT SUB, ENDO
0D168Z9	BYPASS STOMACH TO DUODENUM, ENDO
0D168ZA	BYPASS STOMACH TO JEJUNUM, ENDO
0D168ZB	BYPASS STOMACH TO ILEUM, ENDO
0D168ZL	BYPASS STOMACH TO TRANSVERSE COLON, ENDO
0VLN0DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLN3DZ	OCCLUSION OF R VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0VLN4DZ	OCCLUSION R VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VLP0DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, OPEN APPROACH
0VLP3DZ	OCCLUSION OF L VAS DEFERENS WITH INTRALUM DEV, PERC APPROACH
0VLP4DZ	OCCLUSION L VAS DEFERENS W INTRALUM DEV, PERC ENDO

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0VLQ0DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, OPEN
0VLQ3DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC
0VLQ4DZ	OCCLUSION BI VAS DEFERENS W INTRALUM DEV, PERC ENDO
0VNJ0ZZ	RELEASE RIGHT EPIDIDYMIS, OPEN APPROACH
0VNJ3ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNJ4ZZ	RELEASE RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNK0ZZ	RELEASE LEFT EPIDIDYMIS, OPEN APPROACH
0VNK3ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNK4ZZ	RELEASE LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VNL0ZZ	RELEASE BILATERAL EPIDIDYMIS, OPEN APPROACH
0VNL3ZZ	RELEASE BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VNL4ZZ	RELEASE BILATERAL EPIDIDYMIS, PERC ENDO APPROACH
0VQF0ZZ	REPAIR RIGHT SPERMATIC CORD, OPEN APPROACH
0VQF3ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQF4ZZ	REPAIR RIGHT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQG0ZZ	REPAIR LEFT SPERMATIC CORD, OPEN APPROACH
0VQG3ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS APPROACH
0VQG4ZZ	REPAIR LEFT SPERMATIC CORD, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQH0ZZ	REPAIR BILATERAL SPERMATIC CORDS, OPEN APPROACH
0VQH3ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS APPROACH
0VQH4ZZ	REPAIR BILATERAL SPERMATIC CORDS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQJ0ZZ	REPAIR RIGHT EPIDIDYMIS, OPEN APPROACH
0VQJ3ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQJ4ZZ	REPAIR RIGHT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQK0ZZ	REPAIR LEFT EPIDIDYMIS, OPEN APPROACH
0VQK3ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQK4ZZ	REPAIR LEFT EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQL0ZZ	REPAIR BILATERAL EPIDIDYMIS, OPEN APPROACH
0VQL3ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS APPROACH
0VQL4ZZ	REPAIR BILATERAL EPIDIDYMIS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQN0ZZ	REPAIR RIGHT VAS DEFERENS, OPEN APPROACH
0VQN3ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQN4ZZ	REPAIR RIGHT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQP0ZZ	REPAIR LEFT VAS DEFERENS, OPEN APPROACH
0VQP3ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS APPROACH
0VQP4ZZ	REPAIR LEFT VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0VQQ0ZZ	REPAIR BILATERAL VAS DEFERENS, OPEN APPROACH
0VQQ3ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0VQQ4ZZ	REPAIR BILATERAL VAS DEFERENS, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL50ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, OPEN APPROACH
0UL53ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS APPROACH
0UL54ZZ	OCCLUSION OF RIGHT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL60ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, OPEN APPROACH
0UL63ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS APPROACH
0UL64ZZ	OCCLUSION OF LEFT FALLOPIAN TUBE, PERCUTANEOUS ENDOSCOPIC APPROACH
0UL70ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, OPEN APPROACH
0UL73ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS APPROACH
0UL74ZZ	OCCLUSION OF BILATERAL FALLOPIAN TUBES, PERCUTANEOUS ENDOSCOPIC APPROACH
10A07ZZ	ABORTION OF PRODUCTS OF CONCEPTION, VIA OPENING
10A08ZZ	ABORTION OF PRODUCTS OF CONCEPTION, ENDO
10A07ZW	ABORTION OF PRODUCTS OF CONCEPTION, LAMINARIA, VIA NATURAL OR ARTIFICIAL OPENING
10A00ZZ	ABORTION OF PRODUCTS OF CONCEPTION, OPEN APPROACH
10A03ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH
10A04ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS ENDOSCOPIC APPROACH
10A07ZX	ABORTION OF PRODUCTS OF CONCEPTION, ABORTIFACIENT, VIA NATURAL OR ARTIFICIAL OPENING
0NNC0ZZ	RELEASE RIGHT SPHENOID BONE, OPEN APPROACH
0NNC3ZZ	RELEASE RIGHT SPHENOID BONE, PERCUTANEOUS APPROACH
0NNC4ZZ	RELEASE RIGHT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NND0ZZ	RELEASE LEFT SPHENOID BONE, OPEN APPROACH
0NND3ZZ	RELEASE LEFT SPHENOID BONE, PERCUTANEOUS APPROACH
0NND4ZZ	RELEASE LEFT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNF0ZZ	RELEASE RIGHT ETHMOID BONE, OPEN APPROACH
0NNF3ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNF4ZZ	RELEASE RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNG0ZZ	RELEASE LEFT ETHMOID BONE, OPEN APPROACH
0NNG3ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NNG4ZZ	RELEASE LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNH0ZZ	RELEASE RIGHT LACRIMAL BONE, OPEN APPROACH
0NNH3ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNH4ZZ	RELEASE RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0NNJ0ZZ	RELEASE LEFT LACRIMAL BONE, OPEN APPROACH
0NNJ3ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NNJ4ZZ	RELEASE LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNK0ZZ	RELEASE RIGHT PALATINE BONE, OPEN APPROACH
0NNK3ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NNK4ZZ	RELEASE RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNL0ZZ	RELEASE LEFT PALATINE BONE, OPEN APPROACH
0NNL3ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS APPROACH
0NNL4ZZ	RELEASE LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNM0ZZ	RELEASE RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NNM3ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNM4ZZ	RELEASE RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNN0ZZ	RELEASE LEFT ZYGOMATIC BONE, OPEN APPROACH
0NNN3ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NNN4ZZ	RELEASE LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNP0ZZ	RELEASE RIGHT ORBIT, OPEN APPROACH
0NNP3ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS APPROACH
0NNP4ZZ	RELEASE RIGHT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNQ0ZZ	RELEASE LEFT ORBIT, OPEN APPROACH
0NNQ3ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS APPROACH
0NNQ4ZZ	RELEASE LEFT ORBIT, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNR0ZZ	RELEASE RIGHT MAXILLA, OPEN APPROACH
0NNR3ZZ	RELEASE RIGHT MAXILLA, PERCUTANEOUS APPROACH
0NNR4ZZ	RELEASE RIGHT MAXILLA, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNS0ZZ	RELEASE LEFT MAXILLA, OPEN APPROACH
0NNS3ZZ	RELEASE LEFT MAXILLA, PERCUTANEOUS APPROACH
0NNS4ZZ	RELEASE LEFT MAXILLA, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNT0ZZ	RELEASE RIGHT MANDIBLE, OPEN APPROACH
0NNT3ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS APPROACH
0NNT4ZZ	RELEASE RIGHT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NNV0ZZ	RELEASE LEFT MANDIBLE, OPEN APPROACH
0NNV3ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS APPROACH
0NNV4ZZ	RELEASE LEFT MANDIBLE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQC0ZZ	REPAIR RIGHT SPHENOID BONE, OPEN APPROACH
0NQC3ZZ	REPAIR RIGHT SPHENOID BONE, PERCUTANEOUS APPROACH
0NQC4ZZ	REPAIR RIGHT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQCXZZ	REPAIR RIGHT SPHENOID BONE, EXTERNAL APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0NQD0ZZ	REPAIR LEFT SPHENOID BONE, OPEN APPROACH
0NQD3ZZ	REPAIR LEFT SPHENOID BONE, PERCUTANEOUS APPROACH
0NQD4ZZ	REPAIR LEFT SPHENOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQDXZZ	REPAIR LEFT SPHENOID BONE, EXTERNAL APPROACH
0NQF0ZZ	REPAIR RIGHT ETHMOID BONE, OPEN APPROACH
0NQF3ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQF4ZZ	REPAIR RIGHT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQFXZZ	REPAIR RIGHT ETHMOID BONE, EXTERNAL APPROACH
0NQG0ZZ	REPAIR LEFT ETHMOID BONE, OPEN APPROACH
0NQG3ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS APPROACH
0NQG4ZZ	REPAIR LEFT ETHMOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQGXZZ	REPAIR LEFT ETHMOID BONE, EXTERNAL APPROACH
0NQH0ZZ	REPAIR RIGHT LACRIMAL BONE, OPEN APPROACH
0NQH3ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQH4ZZ	REPAIR RIGHT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQHXZZ	REPAIR RIGHT LACRIMAL BONE, EXTERNAL APPROACH
0NQJ0ZZ	REPAIR LEFT LACRIMAL BONE, OPEN APPROACH
0NQJ3ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS APPROACH
0NQJ4ZZ	REPAIR LEFT LACRIMAL BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQJXZZ	REPAIR LEFT LACRIMAL BONE, EXTERNAL APPROACH
0NQK0ZZ	REPAIR RIGHT PALATINE BONE, OPEN APPROACH
0NQK3ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS APPROACH
0NQK4ZZ	REPAIR RIGHT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQKXZZ	REPAIR RIGHT PALATINE BONE, EXTERNAL APPROACH
0NQL0ZZ	REPAIR LEFT PALATINE BONE, OPEN APPROACH
0NQL3ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS APPROACH
0NQL4ZZ	REPAIR LEFT PALATINE BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQLXZZ	REPAIR LEFT PALATINE BONE, EXTERNAL APPROACH
0NQM0ZZ	REPAIR RIGHT ZYGOMATIC BONE, OPEN APPROACH
0NQM3ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQM4ZZ	REPAIR RIGHT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQMXZZ	REPAIR RIGHT ZYGOMATIC BONE, EXTERNAL APPROACH
0NQN0ZZ	REPAIR LEFT ZYGOMATIC BONE, OPEN APPROACH
0NQN3ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS APPROACH
0NQN4ZZ	REPAIR LEFT ZYGOMATIC BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQNXZZ	REPAIR LEFT ZYGOMATIC BONE, EXTERNAL APPROACH
0NQX0ZZ	REPAIR HYOID BONE, OPEN APPROACH
0NQX3ZZ	REPAIR HYOID BONE, PERCUTANEOUS APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0NQX4ZZ	REPAIR HYOID BONE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NQXXZZ	REPAIR HYOID BONE, EXTERNAL APPROACH
0NRR07Z	REPLACEMENT OF RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR0JZ	REPLACEMENT OF RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NRR0KZ	REPLACEMENT OF RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRR37Z	REPLACEMENT OF RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR3JZ	REPLACEMENT OF RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR3KZ	REPLACEMENT OF RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRR47Z	REPLACEMENT OF RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR4JZ	REPLACEMENT OF RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRR4KZ	REPLACEMENT OF RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRS07Z	REPLACEMENT OF LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRS0JZ	REPLACEMENT OF LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NRS0KZ	REPLACEMENT OF LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NRS37Z	REPLACEMENT OF LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRS3JZ	REPLACEMENT OF LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NRS3KZ	REPLACEMENT OF LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NRS47Z	REPLACEMENT OF LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRS4JZ	REPLACEMENT OF LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NRS4KZ	REPLACEMENT OF LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR07Z	SUPPLEMENT RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUR0JZ	SUPPLEMENT RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NUR0KZ	SUPPLEMENT RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUR37Z	SUPPLEMENT RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

CODE	DESCRIPTION
0NUR3JZ	SUPPLEMENT RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR3KZ	SUPPLEMENT RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUR47Z	SUPPLEMENT RIGHT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR4JZ	SUPPLEMENT RIGHT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUR4KZ	SUPPLEMENT RIGHT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUS07Z	SUPPLEMENT LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUS0JZ	SUPPLEMENT LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, OPEN APPROACH
0NUS0KZ	SUPPLEMENT LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, OPEN APPROACH
0NUS37Z	SUPPLEMENT LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUS3JZ	SUPPLEMENT LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS APPROACH
0NUS3KZ	SUPPLEMENT LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS APPROACH
0NUS47Z	SUPPLEMENT LEFT MAXILLA WITH AUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUS4JZ	SUPPLEMENT LEFT MAXILLA WITH SYNTHETIC SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0NUS4KZ	SUPPLEMENT LEFT MAXILLA WITH NONAUTOLOGOUS TISSUE SUBSTITUTE, PERCUTANEOUS ENDOSCOPIC APPROACH
0RNC0ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, OPEN APPROACH
0RNC3ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH
0RNC4ZZ	RELEASE RIGHT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH
0RND0ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, OPEN APPROACH
0RND3ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS APPROACH
0RND4ZZ	RELEASE LEFT TEMPOROMANDIBULAR JOINT, PERCUTANEOUS ENDOSCOPIC APPROACH

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

ICD-10-CM DIAGNOSIS CODES

For dates of service on or after **October 1, 2015**, the following ICD-10-CM diagnosis codes require review of support documentation by the QIO, KEPRO:

ICD-10 CODE	DESCRIPTION
L91.0	HYPERTROPHIC SCAR
L90.5	SCAR CONDITIONS AND FIBROSIS OF SKIN

SECTION 4 BILLING CODES

BILLING CODES REQUIRING SUPPORT DOCUMENTATION

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SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

The following tables include the CPT and diagnosis codes for Family Planning, and the approved drug list and diagnosis codes for Sexually Transmitted Infections (STIs):

FAMILY PLANNING ICD-10-CM DIAGNOSIS CODES

October 2016 Update

For dates of service on or after **October 1, 2016**, please use the following ICD-10-CM diagnosis codes. For dates of service prior to October 1, 2016, refer to the October 2015 Update included in this section.

ICD-10 CODE	DESCRIPTION
Z30.41	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVE PILLS
Z30.011	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVE PILLS
Z30.013	ENCOUNTER FOR INITIAL PRESCRIPTION OF INJECTABLE CONTRACEPTIVE
Z30.014	ENCOUNTER FOR INITIAL PRESCRIPTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.015	ENCOUNTER FOR INITIAL PRESCRIPTION OF VAGINAL RING HORMONAL CONTRACEPTIVE
Z30.016	ENCOUNTER FOR INITIAL PRESCRIPTION OF TRANSDERMAL PATCH HORMONAL CONTRACEPTIVE DEVICE
Z30.017	ENCOUNTER FOR INITIAL PRESCRIPTION OF IMPLANTABLE SUBDERMAL CONTRACEPTIVE
Z30.018	ENCOUNTER FOR INITIAL PRESCRIPTION OF OTHER CONTRACEPTIVES
Z30.019	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVES, UNSPECIFIED
Z30.09	ENCOUNTER FOR OTH GENERAL CNSL AND ADVICE ON CONTRACEPTION
Z30.2	ENCOUNTER FOR STERILIZATION
Z30.40	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVES, UNSPECIFIED
Z30.42	ENCOUNTER FOR SURVEILLANCE OF INJECTABLE CONTRACEPTIVE
Z30.431	ENCOUNTER FOR ROUTINE CHECKING OF INTRAUTERINE CONTRACEP DEV
Z30.44	ENCOUNTER FOR SURVEILLANCE OF VAGINAL RING HORMONAL CONTRACEPTIVE DEVICE
Z30.45	ENCOUNTER FOR SURVEILLANCE OF TRANSDERMAL PATCH HORMONAL CONTRACEPTIVE DEVICE
Z30.46	ENCOUNTER FOR SURVEILLANCE OF IMPLANTABLE SUBDERMAL

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

ICD-10 CODE	DESCRIPTION
	CONTRACEPTIVE
Z30.49	ENCOUNTER FOR SURVEILLANCE OF OTHER CONTRACEPTIVES
Z30.8	ENCOUNTER FOR OTHER CONTRACEPTIVE MANAGEMENT
Z30.9	ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT, UNSPECIFIED

October 2015 Update

For dates of service on or after **October 1, 2015**, please use the following ICD-10-CM diagnosis codes. For dates of service on or after October 1, 2016, refer to the October 2016 Update included in this section.

ICD-10 CODE	DESCRIPTION
Z30.41	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVE PILLS
Z30.011	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVE PILLS
Z30.013	ENCOUNTER FOR INITIAL PRESCRIPTION OF INJECTABLE CONTRACEPTIVE
Z30.014	ENCOUNTER FOR INITIAL PRESCRIPTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.018	ENCOUNTER FOR INITIAL PRESCRIPTION OF OTHER CONTRACEPTIVES
Z30.019	ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVES, UNSPECIFIED
Z30.09	ENCOUNTER FOR OTH GENERAL CNSL AND ADVICE ON CONTRACEPTION
Z30.2	ENCOUNTER FOR STERILIZATION
Z30.40	ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVES, UNSPECIFIED
Z30.42	ENCOUNTER FOR SURVEILLANCE OF INJECTABLE CONTRACEPTIVE
Z30.430	ENCOUNTER FOR INSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
Z30.431	ENCOUNTER FOR ROUTINE CHECKING OF INTRAUTERINE CONTRACEP DEV
Z30.49	ENCOUNTER FOR SURVEILLANCE OF OTHER CONTRACEPTIVES
Z30.8	ENCOUNTER FOR OTHER CONTRACEPTIVE MANAGEMENT
Z30.9	ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT, UNSPECIFIED

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

APPROVED SEXUALLY TRANSMITTED INFECTION (STI) DRUG LIST

DRUG NAME	DOSAGE
ACYCLOVIR	200 MG
ACYCLOVIR	400 MG
AZITHROMYCIN	1GM
AZITHROMYCIN	2 GM
BENZATHINE PENICILLIN G	2.4 MILLION UNITS
BUTOCONAZOLE 2% CREAM	5 G INTRAVAGINALLY
CEFTRIAXONE	2 GM
CEFTRIAXONE	125 MG
CEFIXIME	400 MG
CIPROFLOXIN	500 MG
CLOTRIMAZOLE 1% CREAM	5 G INTRAVAGINALLY
CLOTRIMAZOLE	100 MG VAGINAL TABLET
DOXYCYCLINE	100 MG

DRUG NAME	DOSAGE
ERYTHROMYCIN BASE	500 MG
ERYTHROMYCIN ETHYLSUCCINATE	800 MG
FAMCIOCLOVIR	250 MG
FLUCONAZOLE	150 MG
LEVOFLOXACIN	250 MG
LEVOFLOXACIN	500 MG
METRONIDAZOLE	2 G
METRONIDAZOLE	500 MG
OFLOXACIN	300 MG
OFLOXACIN	400 MG
TETRACYCLINE	500 MG
TINIDAZOLE	2 G
VALACYCLOVIR	1 G

FAMILY PLANNING APPROVED STI DIAGNOSIS CODES

One course of STI (antibiotic treatment) from the approved list for each organism identified below is allowed per calendar year under the South Carolina Family Planning Waiver. These STIs must be diagnosed during an initial or annual family planning waiver office visit.

The physician must write the diagnosis code on the patient's prescription in order for the pharmacy to fill it. Any applicable copayments for the medications will be the responsibility of the recipient.

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

Family Planning Approved ICD-10-CM STI Diagnosis Codes

For dates of service on or after **October 1, 2015**, please use the following approved ICD-10-CM STI diagnosis codes:

STI DIAGNOSIS	ICD-10 CODE
SYPHILIS	
PRIMARY GENITAL SYPHILIS	A51.0
PRIMARY ANAL SYPHILIS	A51.1
PRIMARY SYPHILIS OF OTHER SITES	A51.2
EARLY SYPHILIS, LATENT	A51.5
EARLY SYPHILIS, UNSPECIFIED	A51.9
SYMPTOMATIC LATE SYPHILIS OF OTHER RESPIRATORY ORGANS	A52.73
OTHER GENITOURINARY SYMPTOMATIC LATE SYPHILIS	A52.76
OTHER SYMPTOMATIC LATE SYPHILIS	A52.79
CHLAMYDIA	
CHLAMYDIAL INFECTION OF LOWER GENITOURINARY TRACT, UNSP	A56.00
CHLAMYDIAL CYSTITIS AND URETHRITIS	A56.01
CHLAMYDIAL VULVOVAGINITIS	A56.02
OTHER CHLAMYDIAL INFECTION OF LOWER GENITOURINARY TRACT	A56.09
OTHER CHLAMYDIAL DISEASES	A74.89
NONSPECIFIC URETHRITIS	N34.1
GONORRHEA	
GONOCOCCAL INFECTION OF LOWER GENITOURINARY TRACT, UNSP	A54.00
GONOCOCCAL CYSTITIS AND URETHRITIS, UNSPECIFIED	A54.01
GONOCOCCAL VULVOVAGINITIS, UNSPECIFIED	A54.02
GONOCOCCAL CERVICITIS, UNSPECIFIED	A54.03
OTHER GONOCOCCAL INFECTION OF LOWER GENITOURINARY TRACT	A54.09
GONOCOCCAL INFECTION OF LOWER GENITOURINARY TRACT WITH PERIURETHRAL AND ACCESSORY GLAND ABSCESS	A54.1
GONOCOCCAL INFECTION OF KIDNEY AND URETER	A54.21
GONOCOCCAL FEMALE PELVIC INFLAMMATORY DISEASE	A54.24
OTHER GONOCOCCAL GENITOURINARY INFECTIONS	A54.29
GONOCOCCAL PHARYNGITIS	A54.5
GONOCOCCAL INFECTION OF ANUS AND RECTUM	A54.6
HERPES	
HERPESVIRAL INFECTION OF UROGENITAL SYSTEM, UNSPECIFIED	A60.00
HERPESVIRAL VULVOVAGINITIS	A60.04

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

STI DIAGNOSIS	ICD-10 CODE
HERPESVIRAL INFECTION OF OTHER UROGENITAL TRACT	A60.09
ANOGENITAL HERPESVIRAL INFECTION, UNSPECIFIED	A60.9
CANDIDIASIS	
CANDIDIASIS OF VULVA AND VAGINA	B37.3
CANDIDAL CYSTITIS AND URETHRITIS	B37.41
CANDIDAL BALANITIS	B37.42
OTHER UROGENITAL CANDIDIASIS	B37.49
TRICHOMONIASIS	
UROGENITAL TRICHOMONIASIS, UNSPECIFIED	A59.00
TRICHOMONAL VULVOVAGINITIS	A59.01
TRICHOMONAL CYSTITIS AND URETHRITIS	A59.03
OTHER UROGENITAL TRICHOMONIASIS	A59.09
TRICHOMONIASIS OF OTHER SITES	A59.8
TRICHOMONIASIS, UNSPECIFIED	A59.9

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

FAMILY PLANNING CPT/HCPCS SERVICES

Modifier FP - Service provided as part of family planning program

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
00851	ANESTHESIA FOR INTRAPERITONEAL PROCEDURES IN LOWER ABDOMEN INCLUDING LAPAROSCOPY; TUBAL LIGATION/TRANSECTION			MAY ONLY BE BILLED WITH STERILIZATION PROCEDURE
00952	ANESTHESIA FOR VAGINAL PROCEDURES (INCLUDING BIOPSY OF LABIA, VAGINA, CERVIX, OR ENDOMETRIUM); HYSTEROSCOPY AND/OR HYSTEROSALPINGOGRAPHY			MAY ONLY BE BILLED WITH STERILIZATION PROCEDURE
11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES	X		
11981	INSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	X		MAY BE BILLED WITH IMPLANON
11982	REMOVAL, NON BIODEGRADABLE DRUG DELIVERY	X		MAY BE BILLED WITH IMPLANON
11983	REMOVAL, WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	X		MAY BE BILLED WITH IMPLANON
36415	COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE	X		
45331	SIGMOIDOSCOPY, FLEX;W/BIOP, SINGLE/MULTI	X		
45378	COLONOSCOPY, FLEXIBLE, DIAGNOSTIC, WITH/ WITHOUT SPECIMEN			

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
55250	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING POSTOPERATIVE SEMEN EXAMINATION(S)			
57170	DIAPHRAGM OR CERVICAL CAP FITTING W/INSTRUCTIONS	X		
58300	INSERTION OF INTRAUTERINE DEVICE	X		
58301	REMOVAL OF INTRAUTERINE DEVICE	X		
58340	CATHETERIZATION AND INDUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY OR HYSTEROSALPINGOGRAPHY	X		MAY ONLY BE BILLED WITH ESSURE PROCEDURE
58565	CATHETERTIZATION AND INDUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY OR HYSTEROSALPINGOGRAPHY	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
58600	HYSTEROSCOPY, SURGICAL; WITH BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE OCCLUSION BY PLACEMENT OF PERMANENT IMPLANTS	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
58615	LIGATION OR TRANSACTION OF FALLOPIAN TUBE(S), AND OR VAGINAL UNILATERAL OR BILATERAL	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
58670	OCCLUSION OF FALLOPIAN TUBE(S) BY DEVICE (E.G., BAND, CLIP VAGINAL OR SUPRAPUBIC APPROACH	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
58671	LAPAROSCOPY, SURGICAL; WITH FULGURATION OF OVIDUCTS (WITH OR WITHOUT TRANSECTION)	X		REQUIRES COMPLETED STERILIZATION FORM PRIOR TO PROCEDURE
71045	X-RAY OF CHEST, 1 VIEW	X		
71250	COMPUTER TOMOGRAPHY THORAX W/O CONTRAST	X		
74740	HYSTEROSALPINGOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION	X		MAY ONLY BE BILLED AFTER ESSURE PROCEDURE
76830	ULTRASOUND, TRANSVAGINAL	X		
76856	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	X		
76857	LIMITED OR FOLLOW-UP (E.G., FOR FOLLICLES)	X		
77065	DX MAMMO INCL CAD UNI	X		
77066	DX MAMMO INCL CAD BI	X		
77067	SCR MAMMO BI INCL CAD	X		
80048	BASIC METABOLIC PANEL	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
80061	LIPID PANEL	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81000	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANY NUMBER OF THESE CONSTITUENTS; NON-AUTOMATED, WITH MICROSCOPY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81001	AUTOMATED, WITH MICROSCOPY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81002	NON-AUTOMATED, WITHOUT MICROSCOPY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81003	AUTOMATED, WITH MICROSCOPY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81005	URINALYSIS; QUALITATIVE OR SEMIQUANTITATIVE, EXCEPT IMMUNOASSAY KIT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81007	BACTERIURIA SCREEN, BY NON-CULTURE TECHNIQUE, COMMERCIAL KIT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81015	MICROSCOPIC ONLY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81020	2 OR 3 GLASS TEST	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
81025	URINE PREGNANCY TES, BY VISUAL COLOR COMPARISON METHODS	X		

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
82270	BLOOD,OCULT/PEROXIDAS ACTIVTY,QUAL;FECES	X		
82274	BLOOD OCCULT,FECAL HEMOG;1-3 DETERMIN	X		
82465	CHOLESTEROL SERUM OR WHOLE BLOOD,TOTAL	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
82947	GLUCOSE;QUANTITA BLOOD EXCP REAGNT STRIP	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
82950	GLUCOSE POST GLUCOSE DOSE (INC GLUCOSE)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
82951	GLUCOSE TOLERANCE TEST(GTT)3SPEC(INC GL)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
83036	HEMOGLOBIN; GLYCOSYLATED (A1C)	X		
83718	LIPOPRO,DIR MSRMNT;HGH DNSTY CHLSTR(HDL)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
84702	GONADOTROPIN, CHORIONIC (HCG); QUANTITATIVE	X		
84703	QUALITATIVE	X		
85007	BLOOD COUNT; BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85008	BLOOD SMEAR, MICROSCOPIC EXAMINATION WITHOUT DIFFERENTIAL WBC COUNT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85009	MANUAL DIFFERENTIAL WBC COUNT, BUFFY COAT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
85013	SPUN MICROHEMATOCRIT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85014	HEMATOCRIT (HCT)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85018	HEMAGLOBIN (HGB)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
85025	COMPLETE BLOOD CELL COUNT (RED CELLS, WHITE BLOOD CELL, PLATELETS), AUTOMATED TEST	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
85027	COMPLETE BLOOD CELL COUNT (RED CELLS, WHITE BLOOD CELL, PLATELETS), AUTOMATED TEST	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
85032	MANUAL CELL COUNT (ERYTHROCYTE, LEUKOCYTE OR PLATELET)EACH	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
86255	FLUORESCENT NONINFECTIOUS AGENT ANTIBODY: SCREEN, EACH ANTIBODY	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
86592	SYPHILIS TEST, NON-TREPONEMAL ANTIBODY; QUALITATIVE (EG, VDRL,RPR, ART)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86593	QUANTITATIVE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86689	ANTIBODY, HTLV OR HIV ANTIBODY, CONFIRMATORY TEST (E.G., WESTERN BLOT)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
86694	ANTIBODY; HERPES SIMPLEX, NON-SPECIFIC TYPE TEST	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86695	HERPES SIMPLEX, TYPE 1	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86696	HERPES SIMPLEX, TYPE 2	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86701	ANTIBODY, HIV-1	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86702	HIV-2	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86703	HIV-1 AND HIV-2, SINGLE ASSAY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86780	ANTIBODY; TREPONEMA PALLIDUM	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
86803	HEPATITIS C ANTIBODY	X		
86804	HEPATITIS C ANTIBODY;CONFIRM TST(IMMUNOB	X		
87081	CULTURE, PRESUMPTIVE, PATHOGENIC ORGANISMS, SCREENING ONLY	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87110	CULTURE,CHLAMYDIA, ANY SOURCE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87164	DARK FIELD EXAMINATION, ANY SOURCE (E.G., PENILE, VAGINAL, ORAL, SKIN); INCLUDES SPECIMEN COLLECTION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
87177	OVA AND PARASITES, DIRECT SMEARS, CONCENTRATION AND IDENTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87205	SMEAR, PRIMARY SOURCE WITH INTERPRETATION; GRAM OR GIEMSA STAIN FOR BACTERIA, FUNGI, OR CELL TYPES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87206	FLUORESCENT AND/OR ACID FAST STAIN FOR BACTERIA, FUNGI, PARASITES, VIRUSES, OR CELL TYPES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87207	SPECIAL STAIN FOR INCLUSION BODIES OR PARASITES (E.G.,MALARIA COCCIDIA, MICROSPORIDIA, TRYPANOSOMES, HERPES VIRUS)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87209	COMPLEX SPECIAL STAIN (E.G., TRICHROME, IRON HEMOTOXYLIN) FOR OVA AND PARASITES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87210	WET MOUNT FOR INFECTIOUS AGENTS (E.G., SALINE, INDIA INK, KOH PREPS)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87220	TISSUE EXAMINATION BY KOH SLIDE OF SAMPLES FROM SKIN, HAIR OR NAILS FOR FUNGI OR ECTOPARASITE OVA OR MITES (E.G., SCABIES)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87270	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOFLUORESCENT TECHNIQUE; CHLAMYDIA TRACHOMATIS	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87480	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CANDIDA SPECIES, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
87481	CANDIDA SPECIES, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87482	CANDIDA SPECIES, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87490	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CHLAMYDIA TRACHMOATIS, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87491	CHLAMYDIA TRACHOMATIS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87510	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); GARDNERELLA VAGINALIS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87511	GARDNERELLA VAGINALIS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87512	GARDNERELLA VAGINALIS, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87528	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); HERPES SIMPLEX VIRUS, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87529	HERPES SIMPLEX VIRUS, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87530	HERPES SIMPLEX VIRUS, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
87531	HERPES VIRUS-6, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87532	HERPES VIRUS-6, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87533	HERPES VIRUS -6, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87534	HIV-1, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87535	HIV-1, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87536	HIV-1 QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87537	HIV-2, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87538	HIV-2 AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87539	HIV-2, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87590	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); NEISSERIA GONORRHOEAE, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87591	NEISSERIA GONORRHOEAE, AMPLIFIED PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
87592	NEISSERIA GONORRHEA, QUANTIFICATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87623	HUMAN PAPILLOMAVIRUS (HPV), LOW RISK TYPES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87624	HUMAN PAPILLOMAVIRUS (HPV), HIGH-RISK TYPES	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87625	HUMAN PAPILLOMAVIRUS (HPV), TYPES 16 AND 18 ONLY, INCLUDES TYPE 45, IF PERFORMED	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87660	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); TRICHOMONAS VAGINALIS, DIRECT PROBE TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87797	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); NOT OTHERWISE SPECIFIED; DIRECT PROBE TECHNIQUE, EACH ORGANISM	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
87850	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; NEISSERIA GONORRHEA	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88108	CYTOPATHOLOGY, CONCENTRATION TECHNIQUE, SMEARS AND INTERPRETATION (E.G., SACCOMANNO TECHNIQUE	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88141	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), REQUIRING INTERPRETATION BY PHYSICIAN	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
88142	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88143	WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88147	CYTOPATHOLOGY SMEARS, CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88148	SCREENING BY AUTOMATED SYSTEM WITH MANUAL RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88150	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88152	WITH MANUAL SCREENING AND COMPUTER ASSISTED RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88153	WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
88155	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL, DEFINITIVE HORMONAL EVALUATION (EG., MATURATION INDEX, KARYOPYKNOTIC INDEX ESTROGENIC INDEX)(LIST SEPARATELY IN ADDITION TO CODE 9S) FOR OTHER TECHNICAL AND INTERPRETATION SERVICES)	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88160	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; SCREENING AND INTERPRETATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88161	PREPARATION, SCREENING, AND INTERPRETATION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88162	EXTENDED STUDY INVOLVING OVER 5 SLIDES AND/OR MULTIPLE STAINS	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88164	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); MANUAL SCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88165	WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88166	WITH MANUAL SCREENING AND COMPUTER ASSISTED RESCREENING UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88167	WITH MANUAL SCREENING AND COMPUTER ASSISTED RESCREENING USING CELL SELECTION AND REVIEW UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
88172	CYTOPATHOLOGY, EVALUATION OF FINE NEEDLE ASPIRATE; IMMEDIATE CYTOHISTOLOGIC	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88173	INTERPRETATION AND REPORT	X		MAY BE BILLED WITH INITIAL OR ANNUAL VISIT ONLY
88174	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION; SCREENING BY AUTOMATED SYSTEM, UNDER PHYSICIAN SUPERVISION	X		
88175	WITH SCREENING BY AUTOMATED SYSTEM AND MANUAL RESCREENING OR REVIEW, UNDER PHYSICIAN SUPERVISION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
88300	PATHOLOGY EXAMINATION OF TISSUE USING A MICROSCOPE, LIMITED EXAMINATION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
88302	LEVEL II SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
88305	PATHOLOGY EXAMINATION OF TISSUE USING A MICROSCOPE, INTERMEDIATE COMPLEXITY	X		STERILIZATION, COLONOSCOPY POLYPS AND BIOPSY
96372	INJECTION BENEATH THE SKIN OR INTO MUSCLE FOR THERAPY, DIAGNOSIS, OR PREVENTION	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
99000	HANDLING AND OR CONVEYANCE OF SPECIMEN FOR TRANSFER FROM THE PHYSICIANS OFFICE TO THE LABORATORY	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
99071	EDUCATIONAL SUPPLIES, SUCH AS BOOKS, TAPES, AND PAMPHLETS, PROVIDED BY THE PHYSICIAN FOR THE PATIENT'S EDUCATION AT COST TO THE PHYSICIAN	X		MAY BE BILLED WITH STERILIZATION PROCEDURE ONLY
99201	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99202	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 20 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99203	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 30 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99204	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 45 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS
99205	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 60 MINUTES	X		TO BE USED FOR A NEW PATIENT ALSO, MUST FOLLOW CPT GUIDELINES FOR COMPONENTS

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
99211	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 5 MINUTES	X		TO BE USED FOR AN ESTABLISHED PATIENT. MAY BE USED AS SUPPLY VISIT BY HEALTH DEPARTMENT
99212	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 15 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT, VISIT TYPICALLY 25 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99215	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT, VISIT TYPICALLY 40 MINUTES	X		TO BE USED FOR ESTABLISHED PATIENT
99238	HOSPITAL DISCHARGE DAY MANAGEMENT, 30 MINUTES OR LESS	X		TO BE USED FOR AN ESTABLISHED PATIENT.
99239	MORE THAN 30 MINUTES	X		TO BE USED FOR AN ESTABLISHED PATIENT.
99241	PATIENT OFFICE CONSULTATION, TYPICALLY 15 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
99242	PATIENT OFFICE CONSULTATION, TYPICALLY 30 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES
99243	PATIENT OFFICE CONSULTATION, TYPICALLY 40 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES
99244	PATIENT OFFICE CONSULTATION, TYPICALLY 60 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES
99245	PATIENT OFFICE CONSULTATION, TYPICALLY 80 MINUTES	X		MAY BE USED WHEN A PROVIDER REFERS A RECIPIENT TO ANOTHER PROVIDER FOR A STERILIZATION PROCEDURE ONLY. MUST FOLLOW CPT GUIDELINES
99401	PREVENTIVE MEDICINE COUNSELING, APPROXIMATELY 15 MINUTES	X		CANNOT BE USED ON THE SAME DAY AS AN OFFICE/CLINIC VISIT

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
99402	PREVENTIVE MEDICINE COUNSELING, APPROXIMATELY 30 MINUTES	X		CANNOT BE USED ON THE SAME DAY AS AN OFFICE/CLINIC VISIT
A4261	CERVICAL CAP FOR CONTRACEPTIVE USE	X		
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE	X		
A4268	CONTRACEPTIVE SUPPLY, CONDOM FEMALE		X	
A4269	CONTRACEPTIVE SUPPLY, SPERMICIDE	X		
A4550	MAJOR SURGICAL TRAY (INCLUDES ANESTHESIA INJECTION)		X	
G0105	SCREENING COLONOSCOPY	X		
G0438	ANNUAL WELLNESS VISIT W/PREV PLAN, INITIAL	X		
G0439	ANNUAL WELLNESS VISIT W/PREVENTATIVE CARE SUBSEQUENT VISIT (ESTABLISHED PATIENT)	X		
J0558	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE 100,000 UNITS	X		
J0561	INJECTION, PENICILLIN G BENZATHINE, 100,000 UNITS	X		
J0696	INJECTION, CEFTRIXONE SODIUM, PER 250 MG			
J1050	INJECTION MEDROXYPROGESTERONE ACETATE (DEPO-PROVERA)	X		
J1950	INJECTION, LEUPROLIDE ACETATE, PER 3.75 MG	X		
J7296	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, (KYLEENA), 19.5 MG	X		

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG	X		
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	X		
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	X		
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (SKYLA), 13.5 MG	X		
J7303	CONTRACEPTIVE HORMONE W/VAGINAL RING	X		
J7304	CONTRACEPTIVE SUPPLY HORMONE PATCH	X		
J7306	LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES	X		
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEW CODE FOR IMPLANON)	X		
Q0111	WET MOUNT	X		
Q0112	ALL POTASSIUM HYDROXIDE (KOH)	X		
S0316	DISEASE MANAGEMENT FOLLOW UP REASSESSMENT		X	
S0320	PH CALL/RN- DISEASE MEM/MONITR; MON		X	
S3645	HIV-1 ANTIBODY TESTING OF ORAL MUCOSAL TRANSUDATE	X		

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

CPT/ HCPCS CODE	DESCRIPTION	REQUIRES FP	FAMILY PLANNING CODES THAT ARE NOT TO BE CODED WITH MODIFIER FP	COMMENTS
S4981	INSERTION OF LEVONORGESTREL RELEASING INTRAUTERINE SYSTEM	X		
S4993	CONTRACEPTIVE PILLS FOR BIRTH CONTROL	X		
S9445	PATIENT EDUCATION, INDIVIDUAL, NOT OTHERWISE CLASSIFIED, NON PHYSICIAN PROVIDER	X		CODE ONLY ALLOWED FOR MEDICAID ADOLESCENT PREGANCY SERVICES (MAPPS)
S9446	PATIENT EDUCATION, GROUP, NOT OTHERWISE CLASSIFIED, NON PHYSICIAN PROVIDER	X		CODE ONLY ALLOWED FOR MEDICAID ADOLESCENT PREGANCY SERVICES (MAPPS)
T1015	CLIMIN VISIT ENCOUNTER; ALL INCLUSIVE	X		CODE ONLY ALLOWED FOR FQHC/RHC PROVIDERS. ONLY ONE ENCOUNTER SERVICE PER DAY IS PERMITTED
T1023	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL	X		CODE ONLY ALLOWED FOR MEDICAID ADOLESCENT PREGANCY SERVICES (MAPPS)

SECTION 4 BILLING CODES

BILLING CODES FOR FAMILY PLANNING

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SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

NON-ELECTIVE ABORTIONS PROCEDURE CODES

Outpatient Hospital Non-Elective Abortion Procedure Codes

Please use the following procedure codes for outpatient hospital services. These procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code.

PROCEDURE CODES	
59812	59820
59821	59830
59870	59200

Inpatient Hospital ICD-10-PCS Non-Elective Abortion Surgical Procedure Codes

For dates of service on or after **October 1, 2015**, please use the following ICD-10-PCS Non-Elective Abortion surgical procedure codes. These procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code.

ICD-10 CODE	DESCRIPTION
0U9900Z	DRAINAGE OF UTERUS WITH DRAINAGE DEVICE, OPEN APPROACH
0U990ZZ	DRAINAGE OF UTERUS, OPEN APPROACH
0U9930Z	DRAINAGE OF UTERUS WITH DRAINAGE DEVICE, PERC APPROACH
0U993ZZ	DRAINAGE OF UTERUS, PERCUTANEOUS APPROACH
0U9940Z	DRAINAGE OF UTERUS WITH DRAINAGE DEVICE, PERC ENDO APPROACH
0U994ZZ	DRAINAGE OF UTERUS, PERCUTANEOUS ENDOSCOPIC APPROACH
0U9970Z	DRAINAGE OF UTERUS WITH DRAINAGE DEVICE, VIA OPENING

SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

ICD-10 CODE	DESCRIPTION
0U997ZZ	DRAINAGE OF UTERUS, VIA NATURAL OR ARTIFICIAL OPENING
0U9980Z	DRAINAGE OF UTERUS WITH DRAINAGE DEVICE, ENDO
0U998ZZ	DRAINAGE OF UTERUS, ENDO
0UC90ZZ	EXTIRPATION OF MATTER FROM UTERUS, OPEN APPROACH
0UC93ZZ	EXTIRPATION OF MATTER FROM UTERUS, PERCUTANEOUS APPROACH
0UC94ZZ	EXTIRPATION OF MATTER FROM UTERUS, PERC ENDO APPROACH
0UJD0ZZ	INSPECTION OF UTERUS AND CERVIX, OPEN APPROACH
0UJD3ZZ	INSPECTION OF UTERUS AND CERVIX, PERCUTANEOUS APPROACH
0UJD4ZZ	INSPECTION OF UTERUS AND CERVIX, PERC ENDO APPROACH
0UPD00Z	REMOVAL OF DRAIN DEV FROM UTERUS & CERVIX, OPEN APPROACH
0UPD01Z	REMOVAL OF RADIOACT ELEM FROM UTERUS & CERVIX, OPEN APPROACH
0UPD03Z	REMOVAL OF INFUSION DEV FROM UTERUS & CERVIX, OPEN APPROACH
0UPD07Z	REMOVAL OF AUTOL SUB FROM UTERUS & CERVIX, OPEN APPROACH
0UPD0DZ	REMOVAL OF INTRALUM DEV FROM UTERUS & CERVIX, OPEN APPROACH
0UPD0HZ	REMOVAL OF CONTRACEP DEV FROM UTERUS & CERVIX, OPEN APPROACH
0UPD0JZ	REMOVAL OF SYNTH SUB FROM UTERUS & CERVIX, OPEN APPROACH
0UPD0KZ	REMOVAL OF NONAUT SUB FROM UTERUS & CERVIX, OPEN APPROACH
0UPD30Z	REMOVAL OF DRAIN DEV FROM UTERUS & CERVIX, PERC APPROACH
0UPD31Z	REMOVAL OF RADIOACT ELEM FROM UTERUS & CERVIX, PERC APPROACH
0UPD33Z	REMOVAL OF INFUSION DEV FROM UTERUS & CERVIX, PERC APPROACH
0UPD37Z	REMOVAL OF AUTOL SUB FROM UTERUS & CERVIX, PERC APPROACH
0UPD3DZ	REMOVAL OF INTRALUM DEV FROM UTERUS & CERVIX, PERC APPROACH
0UPD3HZ	REMOVAL OF CONTRACEP DEV FROM UTERUS & CERVIX, PERC APPROACH
0UPD3JZ	REMOVAL OF SYNTH SUB FROM UTERUS & CERVIX, PERC APPROACH
0UPD3KZ	REMOVAL OF NONAUT SUB FROM UTERUS & CERVIX, PERC APPROACH
0UPD40Z	REMOVE OF DRAIN DEV FROM UTERUS & CERVIX, PERC ENDO APPROACH
0UPD41Z	REMOVE RADIOACT ELEM FROM UTERUS & CERVIX, PERC ENDO

SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

ICD-10 CODE	DESCRIPTION
0UPD43Z	REMOVE INFUSION DEV FROM UTERUS & CERVIX, PERC ENDO
0UPD47Z	REMOVE OF AUTOL SUB FROM UTERUS & CERVIX, PERC ENDO APPROACH
0UPD4DZ	REMOVE INTRALUM DEV FROM UTERUS & CERVIX, PERC ENDO
0UPD4HZ	REMOVE CONTRACEP DEV FROM UTERUS & CERVIX, PERC ENDO
0UPD4JZ	REMOVE OF SYNTH SUB FROM UTERUS & CERVIX, PERC ENDO APPROACH
0UPD4KZ	REMOVE NONAUT SUB FROM UTERUS & CERVIX, PERC ENDO
0UPD70Z	REMOVAL OF DRAINAGE DEVICE FROM UTERUS & CERVIX, VIA OPENING
0UPD71Z	REMOVAL OF RADIOACT ELEM FROM UTERUS & CERVIX, VIA OPENING
0UPD73Z	REMOVAL OF INFUSION DEVICE FROM UTERUS & CERVIX, VIA OPENING
0UPD77Z	REMOVAL OF AUTOL SUB FROM UTERUS & CERVIX, VIA OPENING
0UPD7DZ	REMOVAL OF INTRALUM DEV FROM UTERUS & CERVIX, VIA OPENING
0UPD7JZ	REMOVAL OF SYNTH SUB FROM UTERUS & CERVIX, VIA OPENING
0UPD7KZ	REMOVAL OF NONAUT SUB FROM UTERUS & CERVIX, VIA OPENING
0UPD80Z	REMOVAL OF DRAINAGE DEVICE FROM UTERUS AND CERVIX, ENDO
0UPD81Z	REMOVAL OF RADIOACTIVE ELEMENT FROM UTERUS AND CERVIX, ENDO
0UPD83Z	REMOVAL OF INFUSION DEVICE FROM UTERUS AND CERVIX, ENDO
0UPD87Z	REMOVAL OF AUTOL SUB FROM UTERUS & CERVIX, ENDO
0UPD8DZ	REMOVAL OF INTRALUMINAL DEVICE FROM UTERUS AND CERVIX, ENDO
0UPD8JZ	REMOVAL OF SYNTHETIC SUBSTITUTE FROM UTERUS AND CERVIX, ENDO
0UPD8KZ	REMOVAL OF NONAUT SUB FROM UTERUS & CERVIX, ENDO
0UWD00Z	REVISION OF DRAIN DEV IN UTERUS & CERVIX, OPEN APPROACH
0UWD01Z	REVISION OF RADIOACT ELEM IN UTERUS & CERVIX, OPEN APPROACH
0UWD03Z	REVISION OF INFUSION DEV IN UTERUS & CERVIX, OPEN APPROACH
0UWD07Z	REVISION OF AUTOL SUB IN UTERUS & CERVIX, OPEN APPROACH
0UWD0DZ	REVISION OF INTRALUM DEV IN UTERUS & CERVIX, OPEN APPROACH
0UWD0HZ	REVISION OF CONTRACEP DEV IN UTERUS & CERVIX, OPEN APPROACH
0UWD0JZ	REVISION OF SYNTH SUB IN UTERUS & CERVIX, OPEN APPROACH
0UWD0KZ	REVISION OF NONAUT SUB IN UTERUS & CERVIX, OPEN APPROACH

SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

ICD-10 CODE	DESCRIPTION
0UWD30Z	REVISION OF DRAIN DEV IN UTERUS & CERVIX, PERC APPROACH
0UWD31Z	REVISION OF RADIOACT ELEM IN UTERUS & CERVIX, PERC APPROACH
0UWD33Z	REVISION OF INFUSION DEV IN UTERUS & CERVIX, PERC APPROACH
0UWD37Z	REVISION OF AUTOL SUB IN UTERUS & CERVIX, PERC APPROACH
0UWD3DZ	REVISION OF INTRALUM DEV IN UTERUS & CERVIX, PERC APPROACH
0UWD3HZ	REVISION OF CONTRACEP DEV IN UTERUS & CERVIX, PERC APPROACH
0UWD3JZ	REVISION OF SYNTH SUB IN UTERUS & CERVIX, PERC APPROACH
0UWD3KZ	REVISION OF NONAUT SUB IN UTERUS & CERVIX, PERC APPROACH
0UWD40Z	REVISION OF DRAIN DEV IN UTERUS & CERVIX, PERC ENDO APPROACH
0UWD41Z	REVISE RADIOACT ELEM IN UTERUS & CERVIX, PERC ENDO
0UWD43Z	REVISE INFUSION DEV IN UTERUS & CERVIX, PERC ENDO
0UWD47Z	REVISION OF AUTOL SUB IN UTERUS & CERVIX, PERC ENDO APPROACH
0UWD4DZ	REVISE INTRALUM DEV IN UTERUS & CERVIX, PERC ENDO
0UWD4HZ	REVISE CONTRACEP DEV IN UTERUS & CERVIX, PERC ENDO
0UWD4JZ	REVISION OF SYNTH SUB IN UTERUS & CERVIX, PERC ENDO APPROACH
0UWD4KZ	REVISE OF NONAUT SUB IN UTERUS & CERVIX, PERC ENDO APPROACH
0UWD70Z	REVISION OF DRAINAGE DEVICE IN UTERUS & CERVIX, VIA OPENING
0UWD71Z	REVISION OF RADIOACT ELEM IN UTERUS & CERVIX, VIA OPENING
0UWD73Z	REVISION OF INFUSION DEVICE IN UTERUS & CERVIX, VIA OPENING
0UWD77Z	REVISION OF AUTOL SUB IN UTERUS & CERVIX, VIA OPENING
0UWD7DZ	REVISION OF INTRALUM DEV IN UTERUS & CERVIX, VIA OPENING
0UWD7HZ	REVISION OF CONTRACEP DEV IN UTERUS & CERVIX, VIA OPENING
0UWD7JZ	REVISION OF SYNTH SUB IN UTERUS & CERVIX, VIA OPENING
0UWD7KZ	REVISION OF NONAUT SUB IN UTERUS & CERVIX, VIA OPENING
0UWD80Z	REVISION OF DRAINAGE DEVICE IN UTERUS AND CERVIX, ENDO
0UWD81Z	REVISION OF RADIOACTIVE ELEMENT IN UTERUS AND CERVIX, ENDO
0UWD83Z	REVISION OF INFUSION DEVICE IN UTERUS AND CERVIX, ENDO
0UWD87Z	REVISION OF AUTOL SUB IN UTERUS & CERVIX, ENDO
0UWD8DZ	REVISION OF INTRALUMINAL DEVICE IN UTERUS AND CERVIX, ENDO

SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

ICD-10 CODE	DESCRIPTION
0UWD8HZ	REVISION OF CONTRACEPTIVE DEVICE IN UTERUS AND CERVIX, ENDO
0UWD8JZ	REVISION OF SYNTHETIC SUBSTITUTE IN UTERUS AND CERVIX, ENDO
0UWD8KZ	REVISION OF NONAUT SUB IN UTERUS & CERVIX, ENDO
10D17ZZ	EXTRACTION OF PRODUCTS OF CONCEPTION, RETAINED, VIA OPENING
10D18ZZ	EXTRACTION OF PRODUCTS OF CONCEPTION, RETAINED, ENDO
10A07ZW	ABORTION OF PRODUCTS OF CONCEPTION, LAMINARIA, VIA OPENING
0WHR73Z	INSERTION OF INFUSION DEVICE INTO GU TRACT, VIA OPENING
0WHR7YZ	INSERTION OF OTHER DEVICE INTO GU TRACT, VIA OPENING
10A07ZX	ABORTION OF POC, ABORTIFACIENT, VIA OPENING
3E1K78X	IRRIGATION OF GU TRACT USING IRRIGAT, VIA OPENING, DIAGN
3E1K78Z	IRRIGATION OF GENITOURINARY TRACT USING IRRIGAT, VIA OPENING
3E1K88X	IRRIGATION OF GENITOURINARY TRACT USING IRRIGAT, ENDO, DIAGN
3E1K88Z	IRRIGATION OF GENITOURINARY TRACT USING IRRIGAT, ENDO

ELECTIVE THERAPEUTIC ABORTION PROCEDURE CODES

Outpatient Hospital Elective Therapeutic Abortion Procedure Codes

Please use the following elective therapeutic abortion procedure codes for outpatient hospital services:

PROCEDURE CODES			
59840	59841	59850	59851
59852	59855	59856	59857

SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

Inpatient Elective Therapeutic Abortion ICD-10-CM Diagnosis Codes

For dates of service on or after **October 1, 2015**, please use the following inpatient elective therapeutic abortion ICD-10-CM diagnosis procedure codes:

ICD-10 CODE	DESCRIPTION
O04.5	GENITAL TRACT AND PELVIC INFECTION FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.6	DELAYED OR EXCESSIVE HEMORRHAGE FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.7	EMBOLISM FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.80	(INDUCED) TERMINATION OF PREGNANCY WITH UNSPECIFIED COMPLICATIONS
O04.81	SHOCK FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.82	RENAL FAILURE FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.83	METABOLIC DISORDER FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.84	DAMAGE TO PELVIC ORGANS FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.85	OTHER VENOUS COMPLICATIONS FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.86	CARDIAC ARREST FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.87	SEPSIS FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.88	URINARY TRACT INFECTION FOLLOWING (INDUCED) TERMINATION OF PREGNANCY
O04.89	(INDUCED) TERMINATION OF PREGNANCY WITH OTHER COMPLICATIONS
Z33.2	ENCOUNTER FOR ELECTIVE TERMINATION OF PREGNANCY

Inpatient Elective Therapeutic Abortion ICD-10 PCS Surgical Codes

For dates of service on or after **October 1, 2015**, please use the following inpatient elective therapeutic abortion ICD-10 PCS surgical procedure codes:

ICD-10 PCS CODE	DESCRIPTION
10A07ZZ	ABORTION OF PRODUCTS OF CONCEPTION, VIA OPENING
10A08ZZ	ABORTION OF PRODUCTS OF CONCEPTION, ENDO
10A00ZZ	ABORTION OF PRODUCTS OF CONCEPTION, OPEN APPROACH
10A03ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERCUTANEOUS APPROACH

SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

ICD-10 PCS CODE	DESCRIPTION
10A04ZZ	ABORTION OF PRODUCTS OF CONCEPTION, PERC ENDO APPROACH
10A07ZX	ABORTION OF POC, ABORTIFACIENT, VIA OPENING

SECTION 4 BILLING CODES

BILLING CODES FOR ABORTIONS

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SECTION 5

ADMINISTRATIVE SERVICES

TABLE OF CONTENTS

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The South Carolina Department of Health and Human Services (SCDHHS) administers the South Carolina Healthy Connections Medicaid Program. This section outlines the available resources for Medicaid providers.

CORRESPONDENCE AND INQUIRIES

All correspondence to South Carolina Healthy Connections Medicaid should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. In addition, providers may submit an online inquiry at https://www.scdhhs.gov/contact-us. Inquiries concerning specific claims should also be directed to the PSC, but only after all claims filing requirements have been met. **Allow 45 days from the submission date before requesting the status of the claim.**

BENEFICIARY ELIGIBILITY

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county SCDHHS office for assistance. The contact information for county offices is located on the SCDHHS website at https://www.scdhhs.gov/site-page/where-go-help.

Eligibility Status

To verify eligibility status, please use the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool), which is available 24 hours a day/7 days a week. For information on the Web Tool, you may contact the PSC at 1-888-289-0709.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

The South Carolina Department of Health and Human Services will not supply the UB-04 claim form to providers. Providers should purchase the form in its approved format from the private vendor of their choice.

SCDHHS FORMS

Providers may order SCDHHS forms via email at forms@scdhhs.gov. Copies of forms, including program-specific forms, are also available in the Forms section of this manual.

WEB ADDRESS

Providers should visit the Provider Information page on the SCDHHS Web site at https://www.scdhhs.gov/provider for the most current version of this manual.

To order a paper version of this manual, please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. From the Main Menu, select the Provider Enrollment and Education option. Charges for printed manuals are based on actual costs of printing and mailing.

SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

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FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Reasonable Effort Documentation	04/2014
	Electronic Funds Transfer (EFT) Authorization Agreement	08/2017
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1450	UB-04 (blank; sample only)	
	Sample Remittance Advice	
	Abortion Statement	
	Abortion Statement-sample version	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
DHHS 185	Community Long-Term Care Level of Care Certification Letter (two pages)	11/2003
	Community Long-Term Care Notification Form	12/2004
DHHS 218	ESRD Enrollment	06/2007
DHHS 687	Consent for Sterilization (two pages)	05/2019
	Notice of Termination of Administrative Days	09/2010
	Notification of Administrative Days Coverage	05/2012
	OOS Referral Package (four pages)	05/2014
DHHS 1716ME	Request for Medicaid ID Number	04/2017
	Request for Prior Approval Review By KEPRO	06/2012
	Surgical Justification Review for Hysterectomy	08/2017
	Surgical Justification Review for Hysterectomy (sample version)	08/2017
	Transplant Prior Authorization Request Form & Instructions (two pages)	06/2012

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ DOS _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____
(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

South Carolina Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____

Doing Business As Name (DBA) _____

Provider Address

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____ Medicaid Provider Number _____

Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Provider EFT Contact Information

Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution Address _____

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____

Financial Institution Routing Number _____

Type of Account at Financial Institution (select one) ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (select one)

☐ Provider Tax Identification Number (TIN)

☐ National Provider Identifier (NPI)

REASON FOR SUBMISSION: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____

Authorizing Signature **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals
  Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c	d	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

PROVIDER ID. 000099999 — IN/OUT-PATIENT SERVICES — PAYMENT DATE — PAGE

7777777777 **A** DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

02/28/2014 **B**

1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	DAYS	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S|T|S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	CO PY	LV CL	POS IND	TYP REM	O
V99999 **C**	999999 **D** 999999Z	0213 **E** 213	1 **F** 0	3,015.88 **G**	675.00 **H**	P **I**	2222222222 **J**	B B JACKSON **K**	C **L**	1 **M**	1 **N**		
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	S	1111111111	A B SMITH					
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
								EDITS: L00 758 **AA** L00 990					
								EDITS: L06 714					
	TOTALS	CLAIMS 3 **P**	0 **Q**	10,397.64 **R**	675.00 **S**								

T $0.00 — SCHAP PG TOT

V $675.00 — MEDICAID PG TOT

U $0.00 — SCHAP TOTAL

W $675.00 — MEDICAID TOTAL

X $675.00 * CHECK TOTAL

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

9999999 **Y** CHECK NUMBER

PROVIDER NAME AND ADDRESS

Z

PROVIDER ID. 000099999 — IN/OUT-PATIENT SERVICES — PAYMENT DATE — PAGE

7777777777 (A) DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

PAYMENT DATE: 02/28/2014 (B)

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	DAYS	AMOUNT BILLED (G)	TITLE 19 PAYMENT MEDICAID (H)	S T (I)	RECIPIENT ID. NUMBER (J)	RECIPIENT NAME F M I I LAST NAME (K)	CO PY (L)	LV CL (M)	POS IND (N)	TYP REM (O)	XOV IND
V99999 (C)	999999 (D) 999999Z	0213 (E) 213	0 (F) 0	3,015.88	675.00	P	2222222222	B B JACKSON	C	1	1		
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
								EDITS: L00 758		L00 990			
								EDITS: L06 714					
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
								EDITS: L00 758 (AA)		L00 990			
								EDITS: L06 714					
	TOTALS	CLAIMS 3 (P)	0 (Q)	10,397.64 (R)	675.00 (S)								

SCHAP PG TOT (T) $0.00 — MEDICAID PG TOT (V) $675.00

SCHAP TOTAL (U) $0.00 — MEDICAID TOTAL (W) $675.00

* CHECK TOTAL (X) $675.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

9999999 (Y) CHECK NUMBER

PROVIDER NAME AND ADDRESS (Z)

PROVIDER ID. 000099999 — IN/OUT-PATIENT SERVICES — PAYMENT DATE — PAGE

| 7777777777 (A) | DEPT OF HEALTH AND HUMAN SERVICES | REMITTANCE ADVICE | 02/28/2014 (B) | 2 |

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER (C)	CLAIM REFERENCE NUMBER (D)	SERVICE RENDERED PERIOD MMDDYY-MMDD (E)	DAYS (F)	AMOUNT BILLED (G)	TITLE 19 PAYMENT MEDICAID (H)	STS (I)	RECIPIENT ID. NUMBER (J)	RECIPIENT NAME F M I I LAST NAME (K)	COPY (L)	DRG (M)	TYPE REIM (N)	XOV IND (O)
L0000000	99999999999999900Z	021314-0213	1 1	1,339.25	429.37	P	1234567890	A B SMITH		391	A	
L0000000	99999999999999900Z	101513-1027	12 12	24,536.78	7,162.25	P	1234567890	C B JONES	D	138	C	
L0000000	99999999999999900Z	102213-1026	4 4	3,088.25	429.37	P	1234567890	J Q DOE		391	A	
L0000000	99999999999999900Z	102213-1026	4 4	13,085.84	3,720.97	P	1234567890	R R ROE	D	370	A	
L0000000	99999999999999900Z	101813-1021	3 3	13,152.95	3,438.85	P	1234567890	C D SMITH	D	336	A	
L0000000	99999999999999900Z	102813-1030	2 2	4,672.75	1,394.10	P	1234567890	A B JOHNSON		373	A	
L0000000	99999999999999900Z	102913-1030	1 0	2,873.00	0.00	R	1234567890	J Q PUBLIC		143	U	
								EDITS: L06 761 (AA)				
	TOTALS	CLAIMS 27 (P)	74 (Q)	317,236.27 (R)	50,011.83 (S)							

(T) $0.00 SCHAP PG TOT — (V) $44,539.54 MEDICAID PG TOT

(U) $0.00 SCHAP TOTAL — (W) $50,011.83 MEDICAID TOTAL

(X) $50,011.83 * CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

| 9999999 (Y) | CHECK NUMBER

PROVIDER NAME AND ADDRESS

(Z)

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

PROVIDER ID. 000097427

7777777777 **A**

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE

02/28/2014 **B**

PAGE 3

PROVIDERS OWN REF. NUMBER **C**	CLAIM REFERENCE NUMBER **D**	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F	M	I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
A999999999999	99999999999999900U	-									DEBIT	-27.00	
										PAGE TOTAL:		27.00	0.00

PROVDER INCENTIVE CREDIT AMOUNT **CC**: 0.00

BB

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 91430.19

MEDICAID TOTAL: 0.00

CERTIFIED AMT: 0.00

0.00

TO BE REFUNDED IN THE FUTURE: 0.00

$0.00

ADJUSTMENTS: -27.00

0.00

YOUR CURRENT DEBIT BALANCE: 0.00

* CHECK TOTAL: 91403.19

CHECK NUMBER: 9999999

PROVIDER NAME AND ADDRESS

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: BRANCH BANK & TRUST BANK NUMBER: ACCOUNT #:
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name:_____

Patient's Medicaid ID#:_____

Patient's Address:_____

_____

Physician Certification Statement

I, _____ certify that it was necessary to terminate the pregnancy of_____

_____ for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition:

_____

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____

Physician's Signature Date

****

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

_____ _____

Patient's Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: Jane Doe

Patient's Medicaid ID#: 1234567891

Patient's Address: 111 Maple Drive
Anytown, SC 29999

Physician Certification Statement

I, John Brown certify that it was necessary to terminate the pregnancy of Jane Doe for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: End Stage Renal Failure and Cancer

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

John Brown — Physician's Signature

12/12/04 — Date

****

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____ certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

_____ — Patient's Signature

_____ — Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

Alcohol and Drug Medical Assessment

Patient's Name (Last, First, MI) and I.D. #	
Medicaid Client #	Date of Medical Assessment
Physician's Name and Address	

1. Brief medical history to include hospital admissions, surgeries, allergies. present medications, information (where appropriate) about shared needles, sexual activity/orientation and history of hepatitis and liver disease.

2. History of patient /family involvement with alcohol/drugs.

3. Assessment of patient nutritional status.

ADMA 9/20/90
SCCADA FORM

4. Physical examination to include, but not be limited to, vital signs, inspection of ears, nose, mouth, teeth and gums. Also, inspection of skin for recent and/or old needle marks/tracking, abscesses or scarring from healed abscesses.

5. General assessment of patient cardiovascular system, respiratory system, gastro-intestinal system abd neurological status.

6. Screening for anemia (hematocrit or hemoglobin may be used when physician has machinery available in office).

7.

It is ordered that _____ receive alcohol/drug rehabilitative services.

Physician's Signature and Date

SOUTH CAROLINA COMMUNITY LONG TERM CARE
LEVEL OF CARE CERTIFICATION LETTER
FOR
MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

South Carolina Community Long Term Care has evaluated your application and has determined that:

☐ According to Medicaid criteria, you do not meet requirements for skilled or intermediate care. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long term care facility. Please do not hesitate to contact this office if there is a change in your health status or you become more limited in your ability to care for yourself.

☐ According to Medicaid criteria, you meet the requirements to receive long term care at the following level:

☐ SKILLED ☐ INTERMEDIATE

This Certification Letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

This letter must be presented to the long term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.
Telephone No.

If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

Medicaid certification is automatically cancelled when a client enters a facility with a payment source other than Medicaid; you must again be certified before a Medicaid conversion will be allowed.

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

☐ **If the location of care is hospital, your assessment must be re-evaluated and a new effective period established PRIOR TO TRANSFER TO A LONG TERM CARE FACILITY.**

FOR LONG TERM CARE FACILITY USE

☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)

☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date: _____

Nurse Consultant Signature: _____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER

SENT: Date: _____ Initials: _____

APPEALS

As a Medicaid nursing home or home and community-based wiaver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received pending the decision to the South Carolina Department of Health and Human Services.

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time and place the hearing will take place.

In your request for a fair hearing you must state with specificity which issues(s) you with to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.

COMMUNITY LONG TERM CARE NOTIFICATION FORM

TO:

FROM: CLTC Central Office
Post Office Box 8206
Columbia, SC 29202-8206

CLIENT NAME: SS# MA#

- Client's level of care appears to be skilled. (THIS IS NOT A CERTIFIED LEVEL OF CARE. CLIENT INFORMATION MUST AGAIN BE REVIEWED PRIOR TO CERTIFICATION.)

- Client has been referred to you for case follow-up and services, as appropriate.

IF YOU DISAGREE WITH THIS DETERMINATION, PLEASE READ THE APPEALS NOTICE BELOW:

APPEALS

As a Medicaid recipient, you have the right to a fair hearing regarding this decision. To initiate the appeals process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time, and place the hearing will take place. In your request for a fair hearing, you must state with specificity which issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30^{th}) calendar day following receipt of this notification.

Signature: Date:

Copies sent to:

CLIENT [ ] HOSPITAL [ ] LTC FACILITY [ ] COUNTY DSS [ ]
PHYSICIAN [ ] CAREGIVER/RESPONSIBLE PARTY [ ] OTHER [ ]

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
ESRD ENROLLMENT FOR MEDICAID BENEFICIARIES

PART I – PATIENT INFORMATION

Name:	Date of Birth:	Social Security No:

Address:	Medicaid ID No:	Medicare Eligible?
STREET OR RFD CITY STATE ZIP CODE	Medicare Application Submitted? Yes Date:	

County:	Medicare No:	Effective Date:	Medicare Denied? ☐ Yes ☐ No

REASON FOR DENIAL: _____

_____

PART II – TREATMENT INFORMATION – DIALYSIS

Date of First Treatment:	Transplant Candidate? ☐ Yes ☐ No
Name of Facility Transferred From:	
Mode of Treatment: ☐ HEMODIALYSIS ☐ PERITONEAL DIALYSIS ☐ SELF DIALYSIS	Home Dialysis: TYPE: _____ SUPPLIER: _____

PART III – MEDICAL TRANSPORTATION

Reimbursed by DSS? ☐ Yes ☐ No	Provider of Transportation:

ESRD PROVIDER INFORMATION	DHHS USE ONLY
Clinic Name:	ESRD Enrolled:
NPI or Medicaid Provider ID:	Code:
Physician's Name:	Effective Date:
Form Completed By: NAME TELEPHONE NO. TITLE DATE	Approved By: Date Approved:
Mail To: ESRD SERVICES SCDHHS PO BOX 8206 COLUMBIA, SC 29202-8206	Comments:

Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

_____ (*Medicaid ID*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (mark one or more):

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (*Interpreter's Signature*) _____ (*Date*)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's expected date of delivery: _____
☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)

HHS-687 (04/22)

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

Instructions for Completing DHHS Form 1723

(Consent for Sterilization)

Consent to Sterilization

1. Name of the physician or group scheduled to do the sterilization procedure. If the name of the physician or group is unknown, enter the phrase "OB on call."
2. Name of the sterilization procedure (*e.g.*, bilateral tubal ligation)
3. Birth date of the beneficiary. The beneficiary must be 21 years old when he or she signs the consent form, which would be 30 days prior to the procedure being performed.
4. Beneficiary's name
5. Name of the physician or group scheduled to do the sterilization or the phrase "OB on call"
6. Name of the sterilization procedure
7. Beneficiary's signature and date. If the beneficiary signs with an "X," an explanation must accompany the consent form.
8. Beneficiary's 10-digit Medicaid ID number

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language, the interpreter must complete this section. If an interpreter was not necessary, put an "N/A" in these blanks.

Statement of Person Obtaining Consent

1. Beneficiary's name
2. Name of the sterilization procedure
3. Signature and date of the person who counseled the beneficiary on the sterilization procedure. This date should be the same as the date of the beneficiary's signature date. Also complete the facility address. An address stamp is acceptable if legible.

Physician's Statement

1. Beneficiary's name
2. Date of the sterilization procedure (must match date billed on claim)
3. Name of the sterilization procedure
4. EDC date is required if sterilization is within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours must pass before the sterilization procedure may be performed.
5. An explanation must be attached if an emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours must pass before the sterilization. The sterilization cannot be the reason for the emergency surgery.
6. Physician signature and date. A physician stamp is acceptable. The physician's date must be the same as the sterilization date or after. In the license number field, put the Medicaid Provider ID (either the group or individual physician's Medicaid number).

ADMISSION DATE

DATE

MEDICAID ID NUMBER

ATTENDING PHYSICIAN'S NAME

NOTICE OF TERMINATION OF ADMINISTRATIVE DAYS

This is to inform you that a nursing home bed has been found for you at _____ _____ in _____, South Carolina. The bed will be available to you on _____. If you elect to remain in the hospital after this date, you will be responsible for payment of all services provided to you by _____ _____ Hospital beginning on _____.

You may appeal this Notice of Termination with a written request to:

SCDHHS
Division of Appeals and Hearings
P. O. Box 8206
Columbia, SC 29202-8206

The appeal request must be received by SHHSFC within 30 calendar days from receipt of this letter. If the appeal rules in your favor, you will not be responsible for additional charges. However, if the appeal upholds the Notice of Termination, you are responsible for all charges beginning on the date the nursing home bed was located.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of non-coverage of services from the _____ _____ at _____ on _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of this notice.

(Signature of recipient or person acting on behalf of the recipient) (Time) (Date)

cc: Division of Hospital Services
DHHS

ADMISSION DATE

DATE

MEDICAID ID NUMBER

ATTENDING PHYSICIAN'S NAME

NOTIFICATION OF ADMINISTRATIVE DAYS COVERAGE

This notice is to inform you that the hospital's Utilization Review Committee has determined that beginning _____ further acute hospital care is no longer necessary. Your condition, however, qualifies you for nursing home care.

Limited additional days in the hospital may be approved subject to Medicaid coverage regulations while you and your family actively seek a nursing home bed.

Once an available bed is located, Medicaid payment of your hospital bill will stop. If you refuse to accept an available nursing home bed and remain in the hospital, you will be personally responsible for the additional expense in the hospital.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of the Administrative Day Program from the _____ on _____.
I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of this notice.

(Signature of recipient or person acting on behalf of the recipient)

(Date)

South Carolina
Department of Health and Human Services
P O Box 1412
Columbia, South Carolina 29202-1416
www.scdhhs.gov

Policy for medical treatment outside of the South Carolina Medical Service Area

This serves to clarify our policy for reimbursement of services rendered to a South Carolina Medicaid beneficiary outside the South Carolina Medical Service Area (SCMSA). The service area includes all of South Carolina and regions of North Carolina and Georgia that are within 25 miles of the South Carolina border. All services performed outside of the SCMSA require prior approval. Prior approval guidelines are listed below.

The South Carolina Department of Health and Human Services (SCDHHS) provides compensation to medical providers outside the SCMSA for services rendered to beneficiaries only in the following situations:

- When emergency medical services, pregnancy related services and/or delivery are necessary to protect the health of the beneficiary traveling outside the SCMSA.

- When a SCMSA physician certifies that needed services are not available within the SCMSA and follows SCDHHS protocol in referring the beneficiary to an out-of-state provider. All available resources must have been considered and indicated in the request to SCDHHS for the out-of-state referral. The following guidelines outline the requirements for an out-of-state referral.

Prior to contacting SCDHHS, the referring physician must contact the out of state provider rendering service to the beneficiary and inform them of the beneficiary's Medicaid status. The out-of-state provider must confirm, in writing, that they will enroll in the South Carolina Medicaid program and will accept the Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with a completed Referral Request Form (attached) for out-of-state services.

The written request for out-of-state referrals must include the following information:

- ✓ Beneficiary's name and South Carolina Medicaid identification number
- ✓ Date of Service (state as "tentative" if unscheduled at the time of request)
- ✓ Name, address, telephone number and fax number of the out-of-state provider(s) who will render the medical services (i.e. hospital and physician(s) involved in the beneficiary's medical treatment)
- ✓ An explanation why these services must be rendered out-of-state versus within the SCMSA
- ✓ Identification of any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States
- ✓ A copy of the beneficiary's medical records for the past year relating to the treatment of the condition

Services outside of SCMSA *will not* be approved if:

- ✓ All information on the referral form is not provided
- ✓ The provider rendering the service(s) will not enroll in the South Carolina Medicaid program and adhere to the enrollment criteria
- ✓ The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full

For out-of-state referrals, the referring physician may fax the attached Referral Request Form with supporting documentation to (803) 255-8255 or mail the information to the following address:

SCDHHS
Claims, Operations and Provider Relations
ATTN: Out-Of-State Coordinator
P O Box 1412
Columbia, South Carolina 29202-1416

For information concerning enrollment and claims submission for out-of-state **hospital** providers see section 2, "Out-of-State Hospitals" in the Hospitals Services Provider Manual.

When a beneficiary is in one of the Managed Care Organizations (MCO) the request for out-of-state services needs to be completed through the MCO.

For a complete copy of current policy, please refer to the Physicians, Laboratories and Other Medical Professionals Provider Manual. The most current version of the provider manual is maintained on the SCDHHS web site at www.scdhhs.gov. Section two (2), Policies and Procedures outline the Out-of-State policy and further detail. If you have any additional questions, please contact the Provider Service Center at 1-888-289-0709, submit an online inquiry at http://www.scdhhs.gov/contact-us, or your Managed Care program representative at (803) 898-4614.

South Carolina
Department of Health and Human Services
P O Box 1416
Columbia, South Carolina 29202-1416
www.scdhhs.gov

Referral Request Form for Out-of-State Services

BENEFICIARY INFORMATION

NAME: _____

SC MEDICAID ID#: _____ DATE OF BIRTH: _____

NAME OF GUARDIAN: _____

CONTACT NUMBER: _____

REFERRING PHYSICIAN

NAME: _____

NPI#: _____ SC MEDICAID #: _____

PATIENT IS BEING REFERRED TO: _____
NAME OF FACILITY AND/OR PHYSICIAN (S)

CONDITION REQUIRING TREATMENT: _____

DIAGNOSIS CODE (S): _____

PROCEDURE CODE (S): _____

DATE OF SERVICE: _____ DATE OF RETURN: _____

Medicaid patients, as well as their escort, being referred out-of-state may be provided transportation when necessary. Adequate advance notice, as well as prior approval from SCDHHS, is mandatory in order to make the necessary travel arrangements. Call the Provider Service Center at 888-289-0709 for additional questions.

WILL THE BENEFICIARY REQUIRE LODGING, MEAL REIMBURSEMENT and TRANSPORTATION? **YES**_____**NO**_____

RECOMMENDED MODE OF TRANSPORTATION: _____

Please include as an attachment, an explanation why these services must be rendered out-of-state instead of within the SCMSA. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States. Also, a copy of the beneficiary's medical records, relating to treatment of the condition, for the past year must be included.

I certify that contact has been made with the out-of-state provider. I certify that these services are not available and cannot be provided within the South Carolina service area, which includes North Carolina and Georgia (within 25 miles of the South Carolina border).

_____ _____
SIGNATURE OF REFERRING PHYSICIAN DATE

South Carolina

Department of Health and Human Services
P O Box 1416
Columbia, South Carolina 29202-1416
www.scdhhs.gov

Referral Request Form for Out-of-State Services

OUT-OF-STATE PROVIDER

NAME: _____
NAME OF PHYSICIAN (S) AND/OR FACILITY

ADDRESS: _____

_____

TELEPHONE#: _____ FAX#: _____

I certify that I have agreed to enroll in the South Carolina Medicaid program and I am willing to accept South Carolina Medicaid reimbursement as payment in full.

_____ _____
SIGNATURE OF OUT-OF-STATE PHYSICIAN DATE

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Request for Medicaid ID Number - Infant

I. Provider Information

Provider Name / Hospital Name			Date	
Provider Street Address	City	County	State	ZIP code
Provider Representative (First, Last Name)			Phone	

II. Mother's Information

First Name, Middle Name, Last Name			Date of Birth (mm/dd/yyyy)	
Street Address	City	County	State	ZIP code
Social Security Number		Medicaid ID#		

Is the mother covered by other health insurance? ☐ Yes ☐ No

If yes, does the insurance cover Doctor Visits and Lab Tests? ☐ Yes ☐ No ☐ Unsure

Insurance Company: _____ Policy#: _____

III. Child's Information

First Name, Middle Name, Last Name (If not yet named, enter "Baby Boy" or "Baby Girl")			Date of Birth (mm/dd/yyyy)	
Street Address (If same as mother's, enter "Same")	City	County	State	ZIP code
Name of Birth Facility		County of Birth Facility		

Gender: ☐ Male ☐ Female

Has an application been made for a SSN for the child? ☐ Yes ☐ No

IV. Mail the Completed Form

Mail the completed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia, SC
29202-3101

Fax:

(803) 255-8200

SOUTH CAROLINA MEDICAID PROGRAM
REQUEST FOR PRIOR APPROVAL REVIEW BY KePRO

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ ***MEDICAID#** _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

DX CODE: _____

FACILITY _____ _____
NAME NPI #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA MAIL**

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "CONSENT FOR STERILIZATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ **MEDICAID #** _____
LAST FIRST MI

BIRTHDATE _____ **GRAVITY** _____ **PARITY** _____
MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL _____ _____
NAME NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _____ **PLANNED SURGERY DATE** _____

TYPE OF HYSTERECTOMY PLANNED_____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

_____

_____

_____

_____

_____

_____

_____

_____

HCT ____ **HGB** ____ **CHECK ONE: PREMENOPAUSAL** _____ **POSTMENOPAUSAL** _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

_____

_____

_____

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

_____

_____

_____

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME _____ _____
LAST FIRST MI NPI

ADDRESS _____

CONTACT PERSON _____ **TELEPHONE (_____)** _____

FAX (_____) _____

SIGNATURE _____ **DATE** _____
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 08/01/17

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "CONSENT FOR STERILIZATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME Jane (LAST) Doe (FIRST) (MI) **MEDICAID #** 1234567891

BIRTHDATE 09/09/1970 (MONTH/DAY/YEAR) **GRAVITY** 2 **PARITY** 2

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL Memorial Hospital (NAME) 1234567890 (NPI (IF AVAILABLE))

PLANNED ADMISSION DATE 08/15/10 **PLANNED SURGERY DATE** 08/15/10

TYPE OF HYSTERECTOMY PLANNED Vaginal

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

Dysfunctional uterine bleeding >3 mos and unresponsive to hormonal therapy x 3 consecutive cycles, bleeding, anemia with transfusion x 1. Neg. for endometrial lesion per biopsy 10/04.

HCT 26 **HGB** ___ **CHECK ONE: PREMENOPAUSAL** X **POSTMENOPAUSAL** ___

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

D&C 10/05/09 Dx Lap. 11/09

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME Brown (LAST) Mary (FIRST) Z (MI) 1234567890 (NPI)

ADDRESS 101 East Street Anywhere, SC 22222

CONTACT PERSON John Brown **TELEPHONE** (803) 123-4567

FAX (803) 123-4568

SIGNATURE Mary Brown, MD (ATTENDING PHYSICIAN) **DATE** 06/01/07

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 08/01/17

TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS

In determining whether to provide Prior Authorization, the South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions.

When submitting a completed Transplant Prior Authorization Request Form:

1. The referring South Carolina (SC) Medicaid provider must complete the form.

2. All fields on the form must be completed.

3. Include supporting clinical documentation *(e.g.,* clinical notes, diagnostic studies, lab results)

4. This is not an authorization for payment. Payments are made subject to the beneficiary's eligibility and benefits on the day of service.

5. Providers seeking reimbursement for services must be credentialed with SC Medicaid.

6. You must provide sufficient information to allow us to make a decision regarding your request.

7. If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.

8. Requests for prior authorizations from KePRO may be submitted using one of the following methods.

KePRO Customer Service:	855-326-5219
KePRO Fax #	855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

SCDHHS reserves the right to make recommendations to a center that has provided transplant services to Medicaid beneficiaries in the past. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, as these services are non-covered by SC Medicaid. In addition, a copy of the beneficiary's medical records, relating to the transplant, for up to the past year must be included.

All transplant prior authorization requests require at least 10 days advance notice.

South Carolina
Department of Health and Human Services

Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification**.** Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

NAME OF BENEFICIARY: _____ DATE OF BIRTH: _____

SC MEDICAID ID#: _____

NAME OF GUARDIAN (if applicable): _____ CONTACT NUMBER: _____

REFERRING PHYSICIAN: _____

NPI: _____ _____ SC MEDICAID #: _____

TYPE OF TRANSPLANT: _____ Is the patient receiving a _____ living organ or a _____ cadaveric organ?

EXPECTED DATE OF SERVICE: _____ EXPECTED DATE OF RETURN: _____

WILL THE BENEFICARY REQUIRE TRANSPORTATION? **YES** _____ **NO** _____

RECOMMENDED MODE OF TRANSPORTATION: _____

Medicaid patients, as well as their escort, may be provided transportation when necessary. Prior approval is mandatory in order to make the necessary travel arrangements. Contact the Provider Service Center at 1-888-289-0709 to make travel arrangements.

RENDERING PHYSICIANS/FACILITY

PATIENT REFERRED TO: _____
NAME OF FACILITY AND/OR PHYSICIAN (S)

ADDRESS: _____

TELEPHONE: _____ FAX: _____

NAME OF CONTACT PERSON/COORDINATOR: _____

REQUIRED DOCUMENTATION

- ☐ Letter of Medical Necessity for the transplant, including the following: summary of course of illness, current medications, smoking, alcohol, and drug abuse history
- ☐ Medical records, including physical exam, medical history, and family history
- ☐ Laboratory assessments including serologies
- ☐ Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) – If applicable.

PLEASE ANSWER THE FOLLOWING QUESTIONS

	Yes	No
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management?		
Has the patient had active alcohol, tobacco, or substance abuse within the past 6 months?		
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post transplant care?		
Does the patient have any uncontrolled/untreatable infections or diseases?		

If the answer is "Yes" to any of the above questions, please explain and provide medical documentation.

I certify that the above information is correct and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the SCMSA, that the service is not available and cannot be provided within the SCMSA.

_____ _____
SIGNATURE OF REFERRING PHYSICIAN **DATE**

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Review the resolution instructions below for the edit code(s) that apply to your claim. **Submit a new claim with the corrected information and attach documentation when necessary or applicable to complete the processing of the claim.** If the claim does not require corrections, but needs to be reprocessed as a result of a system update, submit a new claim for processing after the system has been updated. **Remittance Advice pages are not an acceptable form to correct claim errors and will be disregarded.**

Note: For dates of service on or before **September 30, 2015**, the ICD-9-CM manual should be referenced for ICD coding guidance. For dates of service on or after **October 1, 2015**, the ICD-10-CM manual should be referenced for ICD coding guidance.

Edit Code	Description	CARC	RARC	Resolution
007	PAT DAILY INCOME RATE MORE THAN HOME RATE	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Patient's daily recurring income is greater than the nursing facility's daily rate. If the recurring income is incorrect, make the appropriate correction and submit a new claim. If the recurring income is correct, contact the PSC.
050	DATE OF BIRTH/ DATE OF SERV. INCONSISTENT	14 – The date of birth follows the date of service.		The date of birth and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of birth (field 3), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), date of service (field 6) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.
051	DATE OF DEATH/ DATE OF SERV INCONSISTENT	13 – The date of death precedes the date of service.		The date of death and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of service (field 6) **NH CLAIM:** Submit termination DHHS Form 181 with monthly billing. If the date of death is correct according to your records, contact the local county Medicaid office to see if there is an error with the patient's date of death. After verifying that the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
052	ID/RD WAIVER CLM FOR NON ID/RD WAIVER RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with an ID/RD waiver-specific procedure code, but the recipient was not a participant in the ID/RD waiver. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24A unshaded), procedure code (field 24D unshaded) If the recipient's Medicaid ID is correct, the procedure code is correct, and an ID/RD waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. After the system has been updated, submit a new claim.
053	NON ID/RD WAIVER CLM FOR ID/RD WAIVER RECIP	A1 – Claim/service denied.	N34 – Incorrect claim/format for this service.	The claim was submitted for an ID/RD waiver recipient, but the procedure code is not an ID/RD waiver procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24 A unshaded), procedure code (field 24 D unshaded)
055	MEDICARE B ONLY SUFFIX WITH A COVERAGE	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Submit a claim to Medicare Part A.
056	MEDICARE B ONLY SUFFIX/NO A COV/NO 620	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid provider payer identification.	**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 50 A-C). Enter the Medicare Part B payment (fields 54 A-C). Enter the Medicare ID number (fields 60 A-C). The carrier code, payment, and ID number should be entered on the same lettered line, A, B, or C.
057	MEDICARE B ONLY SUFFIX/NO A COV/NO $	107 – Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.		**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 54 A – C) which corresponds with the line on which you entered the Medicare carrier code (fields 50 A – C).
058	RECIP NOT ELIG FOR MED. COMPLEX CHILDREN'S WAIVER SVCS	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
059	MED. COMPLEX CHILDREN'S WAIVER RECIP SVCS REQUIRE PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Contact recipient's PCP to obtain authorization for this service.
060	MED.COMPLEX CHILDREN'S WAIVER, CLAIM TYPE NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
061	INMATE RECIP ELIG FOR EMER INST SVC ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient is eligible for emergency institutional services only. If the service was not directly related to emergency institutional services, service is non-covered. Verify that the claim information was billed correctly. **UB CLAIM:** Only inpatient claims will be reimbursed.
062	HEALTHY CONNECTIONS KIDS (HCK) – RECIPIENT in MCO Plan/Service Covered by MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		This recipient is in the Healthy Connections Kids (HCK) Program and enrolled with an MCO. These services are covered by the MCO. Bill the MCO.
063	NH RECIPIENT NOT COMPLEX CARE	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Contact the Nursing Facility program area to obtain the authorization for the service. Submit the complex care authorization form or complex care termination form with the monthly billing.
079	PRIVATE REHAB UNITS EXCEEDED	273 – Coverage/ program guidelines were exceeded.		The number of units billed for this procedure code exceeds the authorized limit. Refer to the Prior Authorization letter from the QIO to determine the number of units authorized. If the prior authorization unit number is correct, attach the QIO prior authorization letter to the NEW claim for review and consideration for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Date of service (field 45), procedure code (field 44), units (field 46)

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Edit Code	Description	CARC	RARC	Resolution
080	SERVICES NON-COVERED FOR RECIPIENTS OVER 21 YEARS OF AGE	6 – The procedure/ revenue code is inconsistent with the patient's age.	N129 – Not eligible due to the patient's age.	These services are non-covered for South Carolina Medicaid Eligible recipients over the age of 21.Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.
101	INTERIM BILL	135 – Claim denied. Interim bills cannot be processed.		**UB CLAIM:** Verify the bill type (field 4) and the discharge status (field 17). Medicaid does not process interim bills. Please do not file a claim until the recipient is discharged from acute care.
110	PROCEDURE CODE REQUIRES OBESITY PRIMARY DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	M76 - Missing/incomplete/invalid diagnosis or condition.	Verify that the correct procedure code and diagnosis code were billed. Check the current version of the ICD-CM manual for correct coding. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)
117	DRG 469 - PRIN DIAG NOT EXACT ENOUGH	16 – Claim/service lacks information which is needed for adjudication.	M81 –You are required to code to the highest level of specificity.	This is a non-covered DRG. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67), procedure code (field 74)
118	DRG 470 - PRINCIPAL DIAGNOSIS INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Resolution is the same as for edit code 117.
119	INVALID PRINCIPAL DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	This claim contains an invalid principal diagnosis. Verify the valid diagnosis in the current ICD-CM manual and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67)
120	CLM DATA INADEQUATE CRITERIA FOR ANY DRG	A8 – Claim Denied ungroupable DRG.		**UB CLAIM:** Verify data with the medical records department.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
121	INVALID AGE	6 – Procedure/revenue code inconsistent with age.		Validate recipient's date of birth on the claim. If there is a discrepancy on the recipient's file, contact the county Medicaid Eligibility office for correction. If the recipient's date of birth is correct, verify that the correct diagnosis code is billed. Check the most current edition of the ICD-CM manual for the correct gestational age range and weight combination. Make corrections to the field(s) below and submit a new claim. **UB CLAIM:** Date of Birth (field 10), Diagnosis code (fields 67 A-Q)
122	INVALID SEX	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	This claim contains an invalid sex. Make corrections to the field(s) below. **UB CLAIM:** Sex (field 11) Contact your county Medicaid Eligibility office to correct the sex on the recipient's file if there is a discrepancy according to your records. After the county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
123	INVALID DISCHARGE STATUS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	This claim contains an invalid discharge status code. Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes. Make corrections to the field(s) below. **UB CLAIM:** Status (field 17)
125	PPS PROVIDER RECORD NOT ON FILE	CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) provider record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
127	PPS STATEWIDE RECORD NOT ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) statewide record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
128	DRG PRICING RECORD NOT ON FILE	A8 – Claim denied ungroupable DRG.		This DRG is not currently priced by Medicaid. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (fields 67 A-Q), procedure code (field 74)

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Edit Code	Description	CARC	RARC	Resolution
150	TPL COVER VERIFIED/FILING NOT IND ON CLM	22 - This care may be covered by another payer per coordination of benefits.		Please see INSURANCE POLICY INFORMATION for the three-character carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. File the claim(s) with the primary insurance before re-filing to Medicaid. If the carrier that has been billed is not the insurance for which the claim received the edit 150, the provider must file with the insurance carrier that is indicated. If the system needs to be updated, contact the TPL office. After verifying that the system has been updated, submit a new claim. Verify that the information in the fields below was billed correctly. **CMS 1500 CLAIM:** Enter the carrier code (fields 9D and 11C), policy number (fields 9A and 11). If payment is made, enter the total amount(s) paid (fields 9C, 11B and 29). Adjust the balance due (field 30). If payment is denied (i.e., applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Enter the carrier code (field 50). Enter the policy number (field 60). If payment is made, enter the amount paid (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A-B). **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information. Click here for additional resolutions tips at MedicaideLearning.com.

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151	MULTIPLE INS POL/NOT ALL FILED-CALL TPL	22 - This care may be covered by another payer per coordination of benefits.		Eliminate any duplicate primary insurance policy entries ensuring one carrier per block. Medicaid coverage should not be entered in either primary block. If there is no duplicate information, refer to the INSURANCE POLICY INFORMATION, and file the claim(s) with each insurance company listed before re-filing to Medicaid. Documentation must show that each policy has been billed, and that proper coordination of benefits has been followed, *e.g.,* bill primary carrier first, then bill second carrier for the difference. If there are three or more separate third-party payers, the claim must be processed by the Third-Party Liability, attach the documentation to your new claim. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Insurance carrier number (fields 9D and 11C), policy number (fields 9A and 11) **UB CLAIM:** Insurance information (field 50) **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
155	POSS NOT POSITIVE INS MATCH/OTHER ERRORS	22 - This care may be covered by another payer per coordination of benefits.		Bill the primary insurer(s) according to the resolution instructions for edit code 150.
156	TPL VERIFIED/FILING NOT INDICATED ON CLM	22 - This care may be covered by another payer per coordination of benefits.		File a claim with the insurance company listed under INSURANCE POLICY INFORMATION. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. If the insurance company denies payment or makes a partial payment, attach a copy of the explanation of benefits with your claim. If the insurance carrier pays the claim in full, no further action is necessary. **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
165	TPL BALANCE DUE/ PATIENT RESPONSIBILITY MUST BE PRESENT/NUMERIC	16-Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	When there is a third party payer on the claim that is primary to Medicaid, the "patient responsibility", entered in the "balance due" and the co-pay, coinsurance and deductible for the third party payer, cannot be blank or nonnumeric. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Amount paid (field 29), balance due (field 30)

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Edit Code	Description	CARC	RARC	Resolution
170	LAB PROC BILLED/NO CLIA # ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach a copy of your CLIA certification to the new claim.
171	NON-WAIVER PROC/PROV HAS CERT OF WAIVER	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of waiver allows Medicaid reimbursement for waivered procedures only. Lab services billed are not waivered procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
172	D.O.S. NONCOVERED ON CLIA CERT DATE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Medicaid will not reimburse for services outside CLIA certification dates. If your CLIA certification has been renewed, attach a copy of your updated CLIA certificate from CMS to a new claim. Contact your lab director or CMS for current CLIA certificate information.
174	NON-PPMP PROC/PROV HAS PPMP CERT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of PPMP allows Medicaid reimbursement for PPMP procedures only. Lab services billed are not PPMP procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
201	MISSING RECIPIENT ID NUMBER	31 – Claim denied, as patient cannot be identified as our insured.		The recipient's 10-digit Medicaid ID number must be entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
202	MISSING NATIONAL DRUG CODE (NDC)	16 – Claim/service lacks information which is needed for adjudication.	M119 - Missing/incomplete/ invalid/deactivated/withdrawn National Drug Code (NDC).	The NDC is missing from the claim. Make corrections to the field(s) below. **CMS 1500 CLAIM:** NDC (field 24A shaded) **UB CLAIM:** NDC (field 43)
206	MISSING DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The date of service is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
207	MISSING SERVICE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure codes.	The code for the service/procedure is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
208	NO LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	Submit a new claim with the billable services.
209	MISSING LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)
210	MISSING TAXONOMY CODE	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	The taxonomy code is missing from the claim. Taxonomy codes are required when an NPI is shared by multiple legacy provider numbers. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D)
213	LINE ITEM MILES OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles of service is missing from the line item. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
219	PRESENT ON ADMISSION (POA) INDICATOR IS MISSING, DIAGNOSIS IS NOT EXEMPT	A1 – Claim/service denied.	N434 – Missing/incomplete/invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
225	FUND CODE NOT ASSIGNED	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identifier.	The system is unable to crosswalk the information on the claim to an assigned fund code. Verify the correct procedure code, modifier, NPI and/or legacy number was submitted. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 33A & 33B), procedure code (field 24D unshaded), modifier (field 24D unshaded) **UB CLAIM**: Provider ID (field 56), procedure code, modifier (field 44 or 74) **Note:** Fund codes may identify specific procedure codes, modifiers, and provider type/provider specialties. If these are submitted in the wrong combination or entered incorrectly, the system searches but cannot find the appropriate fund code and is unable to process the claim.

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Edit Code	Description	CARC	RARC	Resolution
227	MISSING LEVEL OF CARE	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	The level of care is a required field. Enter the corrected information on a new claim.
233	PRIMARY DIAGNOSIS CODE IS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	The primary diagnosis code is missing. Enter a primary diagnosis code from the current edition of the ICD-CM manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Primary diagnosis code (field 21)
234	PLACE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M77-Missing/incomplete/invalid place of service.	The place of service is missing from the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
239	MISSING LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79-Missing/incomplete/invalid charge.	The line net charge is a required field. Enter the corrected information on a new claim.
243	ADMISSION DATE/START OF CARE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	**UB CLAIM:** Enter the admission date/start of care date (field 12).
244	PRINCIPAL DIAGNOSIS CODE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	**UB CLAIM:** Enter the principal diagnosis code (field 67).
245	TYPE OF BILL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid bill type code (field 4).
246	FIRST DATE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM**: Enter the first date of service (field 6).
247	MISSING LAST DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	**UB CLAIM:** Enter the last date of service (field 6).
248	TYPE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid types of admissions. Enter a valid Medicaid type of admission code (field 14).
249	TOTAL CLAIM CHARGE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Enter revenue code 001 on the total charges line (field 42). This revenue code must be listed as the last field.

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Edit Code	Description	CARC	RARC	Resolution
252	PATIENT STATUS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for patient status. Enter the valid Medicaid patient status code (field 17).
253	SOURCE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing incomplete/ invalid admission source.	**UB CLAIM:** Refer to the most current edition of the NUBC Manual for source of admission. Enter a valid Medicaid source of admission code (field 15).
263	MISSING TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M53 – Missing/incomplete/invalid days or unit(s) of service.	Make the appropriate correction to the claim by entering or correcting the total number of days.
270	DOS/DISCH REQUIRES ICD-9 CODES/ICD-9 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-9 codes, the dates of service must be prior to 10/1/2015. The ICD Indicator field is required and must contain a "9" or be left blank (which will default to a 9) to indicate this is an ICD-9 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
271	DOS/DISCH REQUIRES ICD-10 CODES/ICD-10 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-10 codes, the dates of service must be on or after 10/1/2015. The ICD Indicator field is required and must contain a "0" to indicate this is an ICD-10 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
281	PROCEDURE CODE MODIFIER MISSING	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		The modifier of the billed procedure code is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
300	UB82 FORM NO LONGER ACCEPTED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim/format for this service.	Submit claim on appropriate claim form.
304	TOTAL CLAIM CHARGE NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	The total claim charge is missing or not numeric. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Total charge (field 28)
305	INVALID TAXONOMY CODE	16 – Claim/service lacks information that is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Taxonomy code must be valid. Update the taxonomy code on the claim to the one that the provider registered with SCDHHS or contact Provider Enrollment to add the taxonomy code that is being used on the claim. After Provider Enrollment has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D) Please visit http://www.wpc-edi.com/codes/taxonomy for valid taxonomy codes.
308	INVALID PROCEDURE CODE MODIFIER	4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The modifier for the line item service/procedure is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
309	INVALID LINE ITEM MILES OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
310	INVALID PLACE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M77 – Incomplete/invalid place of service(s).	Medicaid requires the numeric coding for place of service. Enter the appropriate place of service code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
311	INVALID LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
312	MODIFIER NON-COVERED BY MEDICAID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	A modifier not accepted by Medicaid has been filed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
316	THIRD PARTY CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	Incorrect third party code was used. Correct coding would be “1” for denial or “6” for crime victim. If a third party payer is not involved with this claim, the field should be blank. Make corrections to the field(s) below. **CMS-1500 CLAIM:** TPL code (field 10D)
317	INVALID INJURY CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Incorrect injury code was used. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Injury code (field 10 A-C) Correct coding would be "2" for work related accident, "4" for automobile accident, or "6" for other accident.
318	INVALID EMERGENCY INDICATOR / EPSDT REFERRAL CODE	16 – Claim/service lacks information that is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Verify that the emergency indicator/EPSDT referral code is valid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Emergency indicator (field 24C unshaded)
322	INVALID AMT RECEIVED FROM OTHER RESOURCE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter a valid number amount in "amount other sources". Make corrections to the field(s) below. **CMS-1500 CLAIM:** Amount Paid (field 29)
323	INVALID LINE ITEM UNITS OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M53 - Missing/incomplete/invalid days or unit(s) of service.	The units of service for the line item are invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded) **UB CLAIM:** Units (field 46)
330	INVALID LINE ITEM DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid “from” date(s) of service.	The date of service for the line item is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
334	ERRONEOUS SURGERY – DO NOT PAY	233 – Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		Services/Treatment is related to a hospital-acquired condition and no payment is due.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
339	PRESENT ON ADMISSION (POA) INDICATOR IS INVALID	A1- Claim/Service denied.	N434 – Missing/incomplete/ invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
349	INVALID LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		This claim contains an invalid level of care. Enter the corrected information on a new claim.
354	TOOTH NUMBER NOT VALID LETTER OR NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N39 – Procedure code is not compatible with tooth number/ letter.	Enter the valid tooth number or letter (field 15). Verify tooth number or letter with procedure code.
355	TOOTH SURFACE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N75 – Missing or invalid tooth surface information.	Enter the correct tooth surface code (field 16).
356	IMMUNIZATION AND ADMINISTRATION CODES MUST BE INCLUDED ON CLAIM	272 – Coverage/ program guidelines were not met.		Medicaid requires that immunization and administration codes must be on the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
357	MAXIMUM OF THREE ADMINISTRATION UNITS CAN BE BILLED PER DATE OF SERVICE	272 – Coverage/ program guidelines were not met.		Claim exceeds administration units. If there are unit errors, make the appropriate corrections to the field(s) below. If there are no unit errors, the claim will not be considered for payment. **CMS-1500 CLAIM:** Units (field 24G unshaded)
358	SECONDARY ADMINISTRATION CPT CODE NOT ALLOWED PRIOR TO PRIMARY CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
361	SECONDARY PROC CODE NOT ALLOWED PRIOR TO PRIMARY PROC CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
367	ADMISSION DATE/START OF CARE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	The admission date/start of care date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Admission date (field 12)
368	TYPE OF ADMISSION NOT VALID	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Refer to the most current edition of the NUBC manual for valid type of admission. Enter a valid Medicaid type of admission code in the field(s) below. **UB CLAIM:** Admission type (field 14)
369	MONTHLY INCURRED EXPENSES MUST BE VALID	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	This claim contains an invalid monthly expense. Enter the corrected information on a new claim.
370	SOURCE OF ADMISSION INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing/incomplete/ invalid admission source.	Refer to the most current edition of the NUBC manual for valid source of admission. Enter a valid Medicaid source of admission code in the field below. **UB CLAIM:** Admission source (field 15)
373	PRINCIPAL SURG PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	The principal surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Principal procedure date (field 74)
375	OTHER SURGICAL PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	The other surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Other procedure date (field 74 A-E)
376	TYPE OF BILL NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid type of bill in the field(s) below. **UB CLAIM:** Type of bill (field 4)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
377	FIRST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	The first date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
378	LAST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The last date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
379	VALUE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value code. Refer to the most current edition of the NUBC manual for valid value codes. Make corrections to the field(s) below. **UB CLAIM:** Value code (fields 39 – 41 A-D)
380	VALUE AMOUNT INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value amount. Make corrections to the field(s) below **UB CLAIM:** Value amount (fields 39 – 41 A-D)
381	OCCURRENCE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N299 – Missing/incomplete/ invalid occurrence date(s).	This claim contains invalid occurrence date(s). Dates must be six digits and numeric. Make corrections to the field(s) below **UB CLAIM:** Occurrence date (fields 31 – 34 A-B)
382	PATIENT STATUS NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid status codes. Enter a valid Medicaid patient status code (field 17).
383	OCCURR.CODE, INCL. SPAN CODES, INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 – Missing/incomplete/invalid occurrence codes.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid occurrence codes and occurrence span codes. Enter the valid Medicaid occurrence codes (fields 31 – 34, A – B) and the occurrence span codes (fields 35-36, A – B).
384	CONDITION CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M44 – Missing/incomplete/invalid condition code.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid condition codes. Enter a valid Medicaid condition code (fields 18 – 28).
385	TOTAL CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Total charge must be numeric. Enter the correct numeric total charge (field 47).
387	NON COVERED CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Charges must be numeric. Enter the correct charge (field 48).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
390	TPL PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter the numeric payment amount from all primary insurance companies in the field(s) below. Enter 0.00 if no payment was received. If the claim denied by the other insurance company, put a "1" (denial indicator) – see field below. If no third party was involved, delete information entered in the field(s). **CMS 1500 CLAIM:** Third party payment amount (fields - 9C, 11B and 29). If payment is denied by other insurance, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Third party payment amount (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A and B).
391	PATIENT PRIOR PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** Verify the payment amount and enter the correct numeric amount (field 54).
394	OCCURRENCE SPAN CODES"FROM"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "from" date. Dates must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
395	OCCURRENCE SPAN CODES"THRU"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "thru" date. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
400	TPL CARR and POLICY # MUST BOTH BE PRESENT	22 – This care may be covered by another payer per coordination of benefits.		Enter a valid carrier code and a valid policy number. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11) and denial indicator (field 10D) **UB CLAIM:** Carrier code (field 50), policy number (field 60) and denial indicator (field 31 A-34 B).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
401	AMT IN OTHER SOURCES/NO TPL CARRIER CODE	22 – This care may be covered by another payer per coordination of benefits.		Enter the applicable third party insurance information for the carrier code, policy number and amount paid. If there are more than two other insurance companies that have paid, enter the total combined amounts paid by all insurance companies. The total combined amounts should be equal to all amounts received from insurance. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. If the insurance company denied payment, put the denial indicator "1" in the TPL field. If there is no third party involved, be sure all third party fields are deleted of information. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D)
402	DEDUCTIBLE EXCEEDS CALENDAR YEAR LIMIT	1 - Deductible amount		**UB CLAIM:** Refer to the EOMB for the deductible amount (including blood deductible). If the amount entered is incorrect, submit a new claim with the corrected information. If it matches, attach the EOMB/Medicare electronic printout to the new claim for review and consideration of payment. Do not add professional fees in the deductible amount. Professional fees should be filed separately on a CMS-1500 form under the hospital-based physician provider number.
403	INCURRED EXPENSES NOT ALLOWED	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Verify the requested charge amount. If the charge amount is incorrect, submit a new claim with the corrected information.
411	ANESTHESIA PROC REQUIRES ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	An anesthesia procedure requires an anesthesia modifier. Refer to the current list of anesthesia modifiers found in section 2 of your provider manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
412	SURG PROC NOT VALID W/ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	Enter the appropriate anesthesia procedure when an anesthesiologist administers anesthesia during a surgical procedure. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
450	ASD SRVC/PROV OR RECIP DOES NOT MATCH	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is not designated for ASD state plan services. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) to ensure the correct codes were billed. Submit a new claim with the corrected information. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
460	PROCEDURE CODE / INVOICE TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Oral & Maxillofacial Surgeons must file CPT procedure codes on the CMS-1500 and CDT procedure codes on the ADA Claim Form.
463	INVALID TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The total days entered on the claim are invalid. Submit a new claim with the corrected information.
468	CARRIER CODE 619 (MEDICAID) LISTED TWICE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Carrier code 619 is listed twice on either the first or second "other payer" line (field 50). Submit a new claim with the corrected information. Do not remove the 619 after "Medicaid Carrier ID."
469	INVALID LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid line net charge. Submit a new claim with the corrected information.
501	INVALID DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/ invalid procedure date(s).	**UB CLAIM:** This claim contains an invalid date on the revenue line. Enter the correct date (field 45).
502	DOS AFTER THE ENTRY DATE/ JULIAN DATE	110 – Billing date predates service date.		Verify the date of service. A claim cannot be submitted prior to the date of service. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded)
504	PROVIDER TYPE AND INVOICE INCONSISTENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Provider has filed the wrong claim form. Please refer to your provider manual for information on claims filing.
505	MISSING DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/invalid procedure date(s).	**UB CLAIM**: The date is missing from the revenue line. Enter the date (field 45).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
506	PANEL CODE and REVENUE CODE BILLED	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/ invalid revenue code(s).	**UB CLAIM:** Individual panel code and procedure codes included in the panel cannot be billed in combination on the claim for the same dates of service. Submit a new claim with the corrected information.
507	MANUAL PRICING REQUIRED	133 - The disposition of the claim/service is pending further review.		Submit a new claim and attach appropriate clinical documentation (i.e., QIO prior authorization, manufacture pricing, invoices, etc.). Please refer to the appropriate section in your provider manual.
508	NO LINE ITEM RECORD	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	This claim cannot be processed because there is no line item information. Submit a new claim with the corrected information.
509	DOS OVER 2 YRS XOVER/ EXT CARE CLM ONLY	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later. Attach appropriate documentation (Medicare EOMB) to each claim **NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to : MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
510	DOS IS MORE THAN 1 YEAR OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for retroactive eligibility must be received and entered into the claims processing system within six months of the recipient's eligibility being added to the Medicaid eligibility system AND be received within three years from the date of service or date of discharge (for hospital claims). If the above time frames are met, attach one of the following documents listed below with each claim. 1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or 2) The computer generated Medicaid eligibility approval letter notifying the recipient that Medicaid benefits have been approved. This can be furnished by the recipient or the eligibility worker. (This is different from the Certificate of Creditable Coverage.) **For NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to: MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.
513	INCONSISTENT MEDICARE CARRIER CODE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	Enter the correct Medicare Part A or Part B carrier code in the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C) **UB CLAIM:** Carrier code (field 50)
514	PROC RATE/MILE X MILES NOT=SUBMIT CHRG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	Check the calculations for the rates, miles and submitted changes. Submit a new claim with the corrected information.
515	AMBUL/ITP TRANS. MILEAGE LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M22-Missing/incomplete/invalid number of miles traveled.	Check the mileage entered on the claim. If corrections are needed, submit a new claim with the corrected information. For review and consideration of payment, attach clinical documentation to the new claim to substantiate the mileage being billed.
517	WAIVER SERVICE BILLED. RECIPIENT NOT IN A WAIVER.	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted for a waiver-specific procedure code, but the recipient was not a participant in a Medicaid waiver Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
518	PROCEDURE CODE COMBINATION NON-COVERED OR INVALID	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	For further assistance, contact DentaQuest at 1-888-307-6553.
519	CMS REBATE TERM DATE HAS EXPIRED/ENDED	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	If the National Drug Code (NDC) end date has not expired for that particular date of service, make the appropriate correction and attach a copy of drug label indicating the NDC number billed, as well as the expiration date of the drug administered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** NDC (field 24A shaded)
527	WAIVER RECIPIENT/REQUIRES WAIVER CASE MANAGEMENT (WCM) PROVIDER	A1 – Claims/service denied.	N30 – Patient ineligible for this service	This claim was submitted for a waiver recipient, but the provider is not a Waiver Case Management (WCM) provider. Verify that the Medicaid ID, Provider ID and/or NPI and procedure code(s) were billed correctly. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded), Provider ID# (field 24J/field 33)
528	PRTF WAIVER RECIPIENT BUT NOT WAIVER SERVICE	A1 – Claim/service denied.	N379 – Claim level information does not match line level information.	The claim was submitted with a procedure code/service that is not in the PRTF service array. Enter the correct procedure code in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
529	REVENUE CODE BEING BILLED OVER 15 TIMES PER CLAIM	A1 – Claim/service denied.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** This edit code cannot be manually corrected. A new claim must be submitted.
532	RECIPIENT NOT ELIGIBLE FOR NFP WAIVER SERVICES	A1 – Claims/service denied.	N30 – Patient ineligible for this service	The claim was submitted with a Nurse Family Partnership (NFP) Waiver specific procedure code, but the recipient was not eligible for NFP Waiver services. Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
533	DOS IS MORE THAN 3 YEARS OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claim exceeds timely filing limits and will not be considered for payment. Refer to the timely filing guidelines in the appropriate section of your provider manual.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
534	PROVIDER/CCN DO NOT MATCH FOR ADJUSTMENT	16 – Claim/service lacks information which is needed for adjudication.	M47 –Missing/incomplete/invalid internal or document control number.	Review the original claim and verify the provider number from that claim. Make sure that the correct original provider number is entered on the adjustment claim.
536	PROCEDURE-MODIFIER NOT COVERED ON DOS	182 – Procedure modifier was invalid on the date of service.	N517 – Resubmit a new claim with the requested information.	The procedure code and the modifier are not covered for the date of service billed on the claim. Verify that the correct date of service, procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code and modifier (field 24D unshaded)
537	PROC-MOD COMBINATION NON-COVERED/INVALID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Procedure code and modifier (field 24D unshaded) **Note:** If reimbursement is for an assistant surgeon OR multiple births **ONLY** use the Modifier (GB or CG) on the applicable lines(s); attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the **NEW** claim for review and consideration for payment.
538	PATIENT PAYMENT EXCEEDS MED NON-COVERED	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify that the prior payment and the total non-covered amounts were entered correctly. A Medicaid recipient is not liable for charges unless they are non-covered services. Make corrections to the field(s) below. **UB CLAIM:** Prior payments (field 54), Non-covered charges (field 48)
539	MEDICAID NOT LISTED AS PAYER	31 – Patient cannot be identified as our insured.		**UB CLAIM:** Enter Medicaid payer code 619 (field 50 A - C) which corresponds with the line on which you entered the Medicaid ID number (field 60 A – C).
540	ACCOM REVENUE CODE/OP CLAIM INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Room accommodation revenue codes cannot be used on an outpatient claim. If the room accommodation revenue codes are correct, check the bill type (field 4) and the Health Plan ID (field 51).
541	MISSING LINE ITEM/REVENUE CODE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code (s).	**UB CLAIM:** The revenue code for the line item is missing. The two digits before the edit code tell you on which line the revenue code is missing. Enter the correct revenue code (field 42) for that line.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
542	BOTH OCCUR CODE and DATE NEC INC SPAN CODE	16 – Claim/service lacks information which is needed for adjudication.	M46 – Missing/incomplete/invalid occurrence span codes.	**UB CLAIM:** If you have entered an occurrence code (fields 31 – 36 A and B), an occurrence date must be entered. If you have entered an occurrence date in any of these fields, an occurrence code must also be entered.
543	VALUE CODE/AMOUNT MUST BOTH BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** If you have entered a value code (fields 39 through 41 A - D), a value amount must also be entered. If you have entered a value amount in these fields, a value code must also be entered
544	NURSING HOME CLAIMS SUBMITTED VIA 837	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	For further assistance, contact South Carolina Medicaid EDI Support Center at 1-888-289-0709.
545	NO PROCESSABLE LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	All lines on the claim have been rejected or deleted. This edit cannot be manually corrected. Submit a new claim with the corrected information.
546	SURGICAL PROCEDURE MUST BE REPORTED AT THE REVENUE CODE LINE LEVEL	16 – Claim/service lacks information which is needed for adjudication.	M20 – Missing/incomplete/invalid HCPCS.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code(s) on the claim at the revenue code line level (field 44).
547	PRINCIPAL SURG PROC AND DTE REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code and date (field 74).
548	OTHER SURG PROC AND DATE MUST BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** This claim is incomplete. Enter the other surgical procedure codes and dates (fields 74 A – E).
550	REPLACE/VOID BILL/ORIGINAL CCN MISSING	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**UB CLAIM:** Check the remittance advice for the paid claim you are trying to replace or cancel to find the CCN. Enter the CCN (field 64).
551	TYPE ADMISSION/SOURCE CODE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Check the most current edition of the NUBC manual for valid codes for the type of admission and source of admission. Enter the valid Medicaid codes in the field(s) below and submit a new claim. **UB CLAIM:** Admission type (field 14), admission source (field 15)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
552	MEDICARE INDICATED/NO MEDICAID LIABILITY	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicare coverage was indicated on the claim form. Enter the correct and complete insurance information in the field(s) below. **CMS-1500 CLAIM:** Insurance carrier code (fields 9D and 11C), policy number (field 9A and 11), insurance amount paid (fields 9C and 11B) **UB CLAIM:** Insurance carrier code (field 50), policy number (field 60), insurance amount paid (field 54)
553	ALLOW AMT=ZERO/UNABLE TO DETERMINE PYMT	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Information is incorrect or missing which is necessary to allow the Medicaid system to calculate the payment for the claim. Check for errors in the following fields: revenue codes (field 42), CPT codes (field 44), ICD surgical codes (field 74), diagnosis codes (field 67), condition codes (fields 18 – 28) and value codes (fields 39-41 A-D) as applicable. If this edit code appears with other edit codes, it may be resolved by correcting the other edit codes first
554	VALUE CODE/3RD PARTY PAYMENT INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	**UB CLAIM:** If you have entered value code 14 (fields 39 through 41 A – D), you must also enter a prior payment (field 54).
555	TPL PAYMENT > PAYMENT DUE FROM MEDICAID	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the payment amount you have entered in prior payment (field 54). If the amount is correct, no payment from Medicaid is due. Do not submit a new claim.
557	CARR PYMTS MUST = OTHER SOURCES PYMTS	22 – This care may be covered by another payer per coordination of benefits.		If any amount appears in the amount received from insurance field, you must indicate a third party payment. If there is no third party insurance involved, delete information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)
558	REVENUE CHGS NOT WITHIN +- $1 OF TOTAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Recalculate your revenue charges (field 47). If a line has been deleted by you on a previous claim submission the charges on these lines should no longer be added into the total charges.
559	MEDICAID PRIOR PAYMENT NOT ALLOWED	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Prior payment from Medicaid (field 54 A - C) should never be indicated on a claim. Make the appropriate correction.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
560	REVENUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** Check for revenue code errors (field 42). Revenue code 100 is an all-inclusive revenue code and cannot be used with any other revenue code except 001, which is the total charges revenue code.
561	CLAIM ALREADY DEBITED (RETRO-MEDICARE), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Medicare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
562	CLAIM ALREADY DEBITED (HEALTH CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Healthcare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
563	CLAIM ALREADY DEBITED (PAY & CHASE CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicaid Pay & Chase claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
564	OP REV 450,459,510,511 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes should never appear in combination on the same claim. If a recipient was seen in the emergency room, clinic, and treatment room (field 14) on the same date of service for the same or related condition, charges for both visits should be combined under either revenue code 450, 510, or 761 (field 42). If the recipient was seen in the ER and clinic on the same date of service for unrelated conditions, both visits should be billed on separate claims using the correct revenue code. If the recipient is a PEP member, and was triaged in the ER, the submitted claim should be filed with only revenue code 459. No other revenue codes should be filed with revenue code 459.
565	THIRD PARTY PAYMENT/NO 3RD PARTY ID	22 - This care may be covered by another payer per coordination of benefits.		**UB CLAIM:** If a prior payment is entered (field 54), information in all other TPL-related fields (50 and 60) must also be entered.
567	NONCOV CHARGES > OR = TOTAL CHARGES	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Check the total of non-covered charges (field 48) and total charges (field 47) to see if they were entered correctly. If they are correct, no payment from Medicaid is due. If incorrect, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
568	CORRESPONDING ADJUSTMENT (VOID) IS SUSPENDED OR DENIED	107 –The related or qualifying claim/service was not previously paid or identified on this claim.		Review the edit code assigned to the void adjustment claim to determine if it can be corrected. If the void adjustment claim can be corrected, make the necessary changes and submit a new claim
569	ORIGINAL CCN IS INVALID OR ADJUSTMENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document number.	Check the original CCN on the Form 130 as it is either invalid or a CCN for an adjustment claim. Correct the Form 130 and resubmit.
570	OP REV 760 762, 769 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes (field 42) cannot be used in combination for the same day (field 45); bill either revenue code 762 or 769 on an outpatient claim.
575	REPLACE/VOID CLM/CCN INDICATED NOT FOUND	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**NOTE:** Only paid claims can be replaced or voided. Review the original claim and verify the claim control number (CCN) and recipient Medicaid ID number from that claim. Make sure that the correct original CCN and recipient Medicaid ID number are on the new claim. **UB CLAIM:** Check the CCN you have entered (field 64 A – C) with the CCN on the remittance advice of the paid claim you want to replace or void. If this edit appears with other edits, it may be corrected by correcting the other edit codes. If edit code 575 and 863 are the only edits on the replacement claim (new claim), the replacement claim criteria have not been met (see Section 3 on replacement claims).
576	TYPE OF BILL AND PROVIDER TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete invalid type of bill.	**UB CLAIM:** If the bill type you have entered (field 4) is 131 or 141, you must use your outpatient number (field 51). If the bill type is 111 (field 4), you must use your inpatient number.
584	NATIVE AMERICAN HEALTH SERVICE PROCEDURE-MODIFIER COMBINATION NON-COV/INVALID	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code and modifier (field 24D unshaded)
587	1ST DATE OF SERV SUBSEQUENT TO LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" and "through" dates (field 6). "From" date must be before "through" date. Be sure you check the year closely.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
588	1ST DOS SUBSEQUENT TO ENTRY DATE	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" date of service (field 6). Be sure to check the year closely.
589	LAST DOS SUBSEQUENT TO DATE OF RECEIPT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "through" date of service (field 6). Be sure to check the year closely.
590	NO DISCHARGE DATE ON FINAL BILL	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Enter the discharge date (field 6). Submit a new claim with the corrected information.
591	NCCI – PROCEDURE CODE COMBINATION NOT ALLOWED	236 - This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative.		This procedure code combination is not allowed on the same date of service. Therefore, only one procedure code was paid. Note: The National Correct Coding Initiative (NCCI) does not allow the rendering or payment of certain procedure codes on the same date of service. For NCCI guidelines and specific code combinations; please refer to Medicaid bulletins about NCCI edits or the CMS website.
594	FINAL BILL/DISCHRG DTE BEFORE LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Check the occurrence code 42 and date (fields 31 through 34 A and B), and the "through" date (field 6). These dates must be the same.
597	ACCOMODATION UNITS/STMT PERIOD INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Check the dates entered (field 6); the covered days calculated (field 7); the discharge date (fields 31 through 34 A – B) and the units entered for accommodation revenue codes (field 42) the discharge date and "through" date must be the same). If the dates (field 6) are correct, the system calculated the correct number of days, so the units for accommodation revenue codes should be changed. If the dates are incorrect, correcting the dates will correct the edit.
598	QIO INDICATOR 3/ APPROVAL DATES REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** If condition code C3 is entered (fields 31 through 34 A – B), the approved dates must be entered in occurrence span, (fields 35-36 A or B).
599	QIO DATES/OCCUR SPAN DATES N/SEQUENCED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The dates which have been entered (fields 35 - 36 A or B) (occurrence span), do not coincide with any date in the statement covers dates (field 6). There must be at least one date in common in these two fields.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
600	QIO DATE/STATEMENT COVERS DATES DON'T OVERLAP	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The date(s) of service do not coincide with statement covers dates (field 6). Verify the approved date(s) received from the QIO are correct.
603	REVENUE/CONDITION/ VALUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Medicaid only sponsors a semi-private room. When a private room revenue code is used, condition code 39 or value codes 01 or 02 and value amounts must be on the claim. See current NUBC manual for definition of codes. Make corrections to the field(s) below. **UB CLAIM:** Condition codes (fields 18-28), value codes (39-41 A-D), revenue codes (field 42)
605	NCCI - UNITS OF SERVICE EXCEED LIMIT	273 – Coverage/ program guidelines were exceeded.		The number of units billed on the specified line exceeds the allowable limit based on NCCI guidelines. **Note:** For NCCI guidelines, please refer to Medicaid bulletins about NCCI edits or the CMS website.
606	CASE MANAGEMENT PROVIDER/SERVICE NOT CASE MANAGEMENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Verify that the correct taxonomy code has been entered on the claim. Submit a new claim with the corrected information. Make corrections to the field below: **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded)
636	COPAYMENT AMOUNT EXCEEDS ALLOWED AMOUNT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		The Medicaid recipient is responsible for a Medicaid copayment for this service/date of service. The allowed payment amount is less than the recipient's copayment amount; therefore no payment is due from Medicaid. Please collect the copayment from the Medicaid recipient. Do not submit a new claim.
637	COINS AMT GREATER THAN PAY AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the coinsurance amount (fields 39 A-41 D). If the coinsurance amount is correct, attach a copy of the Medicare EOMB.
642	MEDICARE COST SHARING REQUIRES COINS/DEDUCTIBLE	16 – Claim/Service lacks information which is needed for adjustment.	N479 – Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**UB CLAIM:** For Medicaid to consider payment of the claim, the Medicare coinsurance and deductible (fields 39 – 41 A-D) must be present.
672	NET CHRG/TOTAL DAYS X DAILY RATE UNEQUAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	Make the appropriate correction(s) to calculations on the claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
673	REJECT LOC 6 - EXCLUDES SWING BEDS	96 – Non-covered charge(s).	N188 – The approved level of care does not match the procedure code submitted.	If there is a recurring income change that impacts the coinsurance payment, submit a new claim and attach appropriate documentation (Form 181, EOMB).
674	NH RATE - PAT DAY INC NOT = PAT DAY RATE	16 – Claim/service lacks information which is needed for adjudication.	N153 – Missing/incomplete/invalid room and board rate.	Make the appropriate corrections to the rate amounts on the claim.
690	OTHER SOURCES AMT MORE THAN MEDICAID AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify and correct the dollar amounts entered in the insurance payment field(s) below. If the amounts are correct, no payment is due from Medicaid. Do not submit a new claim. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)
693	MENTAL HEALTH VISIT LIMIT EXCEEDED	273 – Coverage/ program guidelines were exceeded.		Additional services require Prior Authorization from the QIO. If the authorization number is incorrect, submit a new claim with the corrected information. Contact the QIO for review and consideration of authorization for additional visits.
700	PRIMARY/PRINCIPAL DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires the complete diagnosis code as specified in the current edition of Volume I of the ICD-CM manual, (including fifth digit sub-classification when listed). Check for valid diagnosis code in Volume I of the ICD-CM manual and make corrections to the field (s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
701	SECONDARY/ OTHER DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 700 and submit a new claim. The secondary diagnosis code appears in the fields below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
703	RECIP AGE/PRIM/PRINCIPAL DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and date of birth are entered on the claim. The date of birth in our system is based on the claim run date. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (field 67)
704	RECIP AGE/SECONDARY/OTHER DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 703 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (fields 67 A-Q)
705	RECIP SEX/PRIM/PRINCIPAL DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (field 67)
706	RECIP SEX/SECONDARY/OTHER DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 705 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
707	PRIN. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-CM manual. The diagnosis code requires a fourth or fifth digit. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
708	SEC. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 707 with corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)
709	SERV/PROC CODE NOT ON REFERENCE FILE	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Check the most current applicable provider manual to verify that the correct procedure code is being billed. If the procedure code is incorrect, submit a new corrected claim. If the code is correct, attach appropriate documentation to your new claim for review and consideration for payment.
710	SERV/PROC/DRUG REQUIRES PA-NO NUM ON CLM	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	The claim is missing the required prior authorization number. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **NOTE**: If the prior authorization number was not obtained prior to rendering the service, you will not be considered for payment.
711	RECIP SEX - SERV/PROC/DRUG INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	The recipient's sex is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 44)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
712	RECIP AGE-PROC INCONSIST/NOT ID/RD RECIP	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 44)
713	NUM OF BILLINGS FOR SERV EXCEEDS LIMIT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Check the number of units on the specified line to be sure the correct number of units has been entered for service being billed. If the number of units is correct, check the procedure code to be sure it is correct. For review and consideration for payment of additional units, submit a new claim and attach appropriate clinical documentation to substantiate the services being billed. Please refer to the applicable provider policy manual for the specific documentation requirements. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
714	SERV/PROC/DRUG REQUIRES DOC-MAN REVIEW	133 – The disposition of the claim/service is pending further review.		The service/procedure has to be reviewed by Medicaid prior to payment. Attach appropriate clinical documentation (i.e., Sterilization Consent Form 1723, medical records, etc.) to the new claim for manual review. Please refer to the applicable provider policy manual for the specific documentation requirements.
715	PLACE OF SERVICE/PROC CODE INCONSISTENT	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Check the procedure code and the place of service code to be sure that they are correct. If incorrect, make corrections to the field(s) below. If the procedure code is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment verifying where the procedure/service was provided. **CMS-1500 CLAIM:** Place of service (field 24B unshaded), procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
716	PROV TYPE INCONSISTENT WITH PROC CODE	8 – The procedure code is inconsistent with the provider type/ specialty (taxonomy).	N95 – This provider type/provider specialty may not bill this service.	The type of provider rendering this service/procedure code is NOT authorized. If the provider type is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment.
717	SERV/PROC/DRUG NOT COVERED ON DOS	A1 – Claim/service denied.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The service/procedure is not covered for the date of service billed on the claim. Check the procedure code and the date of service on the indicated line to be sure both are correct. The procedure code may have been deleted from the program or changed to another procedure code.
718	PROC REQUIRES TOOTH NUMBER/SURFACE INFO	16 – Claim/service lacks information which is needed for adjudication.	N37 – Missing/incomplete/ invalid tooth number/letter.	The procedure requires either a tooth number and/or surface information (fields 15 and 16).
719	SERV/PROC/DRUG ON PREPAYMENT REVIEW	133 – The disposition of this claim/service is pending further review.		Check the prior authorization number, procedure code(s) and modifier(s) to ensure that the information on the claim matches the information on the prior approval letter. Attach appropriate documentation to the claim for review and consideration for payment. Refer to the applicable provider policy manual for the specific documentation requirements.
720	MODIFIER 22 REQUIRES ADD'L DOCUMENT	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	For review and consideration for payment, attach appropriate clinical documentation (i.e., medical records, radiology reports, operative notes, anesthesia records, etc.) to the new claim to justify the unusual procedural services, increased intensity indications, difficulty of procedure or severity of patient's condition for review and consideration for payment.
721	CROSSOVER PRICING RECORD NOT FOUND	A1 – Claim/service denied.	N8 - Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data to adjudication.	Pricing record not found for the specific procedure code and modifier being billed. Please verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** If the procedure code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment. Do not submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
722	PROC MODIFIER and SPEC PRICING NOT ON FILE	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** The Medicaid pricing system is programmed specifically for procedure codes, modifiers, and provider specialties. If these are submitted in the wrong combination, the system searches but cannot "find" a price, and the line will automatically reject with edit code 722. Attaching documentation for review and consideration for payment or system updates is not applicable to all provider types. Please refer to the appropriate policy manual for procedure codes and modifiers that are applicable to your provider type/specialty to ensure that you are using the correct procedure code and modifier. A common error is entering the incorrect modifier or entering no modifier. If the code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment.
724	PROCEDURE CODE REQUIRES BILLING IN WHOLE UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 –Missing/incomplete/invalid days or unit(s) of service.	Verify that the units were billed correctly for the procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
725	INCONTINENCE MODIFIER INCONSISTENT	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Correct the procedure code and modifier. Check the Web Tool for the RSP status of the recipient. Contact the Service Coordinator to verify the correct procedure code and modifier were authorized. Make corrections to the field(s) below. **CMS 1500 CLAIM**: Procedure code (field 24D unshaded) and modifier (24D unshaded)
727	DELETED PROCEDURE CODE/CK CPT MANUAL	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid, procedure code(s).	Check the procedure code and the date of service to verify their accuracy. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44), date of service (field 45)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
732	PAYER ID NUMBER NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid provider payer identifier.	Verify that the correct insurance carrier code information is entered on the claim. To view a complete listing of carrier codes, visit the Provider Information webpage on the DHHS website http://provider.scdhhs.gov. The carrier code listing is also included in the provider manuals. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance carrier number (field 9D and 11C) **UB CLAIM:** Insurance carrier number (field 50)
733	INS INFO CODED, PYMT OR DENIAL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA83 – Did not indicate whether we are the primary or secondary payer.	**CMS-1500 CLAIM:** If any third-party insurer has not made a payment, there should be a TPL denial indicator. If all carriers have made payments, there should be no TPL denial indicator. If payment is denied (*i.e.,* applied to the deductible, policy lapsed, etc.) by either primary insurance carrier, put a "1" (denial indicator) and 0.00 for the amount insurance paid. If there are multiple insurers and any payer made a 0.00 payment, put a "1" (denial indicator) and 0.00 for the amount the insurance paid. If payment is made, remove the "1" from the TPL indicator field and enter the amount(s) insurance paid and total combined amount received. Adjust the net charge in the balance due. If no third party insurance was involved, delete all information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D) **UB CLAIM:** If any third-party insurer has not made a payment, there should be a TPL occurrence code and date (fields 31-34 A-B). If payment is denied show 0.00 (field 54). If payment is made enter the amount (field 54) and TPL indicator (fields 31 A-34 B).
734	REVENUE CODE REQUIRES UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 -Missing/incomplete/invalid days or unit(s) of service.	**UB CLAIM:** The revenue code listed (field 42) requires units of service (field 46).
735	REVENUE CODE REQUIRES AN ICD SURGICAL PROCEDURE OR DELIVERY DIAGNOSIS CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	**UB CLAIM:** On inpatient claims w/ revenue codes 360 OR, 361 OR-Minor, or 369 OR-Other, an ICD surgical code is required (fields 74 A-E). On inpatient claims w/ revenue codes 370 Anesthesia, 710 Recovery Room, 719 Other Recovery Room or 722 Delivery Room, a delivery diagnosis code is required (fields 67 A-Q) or an ICD surgical code is required (fields 74 A-E).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
736	PRINCIPAL SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** Verify the correct procedure code was submitted (field 74). The two digits in front of the edit code on the remittance advice identify which surgical procedure code is not on file.
737	OTHER SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** Follow the resolution for edit code 736, except the procedure code (fields 74 A-E).
738	PRINCIPAL SURG PROC REQUIRES PA/NO PA #	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** Enter the prior authorization number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
739	OTHER SURG PROC REQUIRES PA/NO PA NUMBER	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** Follow the resolution for edit code 738.
740	RECIP SEX/PRINCIPAL SURG PROC INCONSIST	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 74)
741	RECIP SEX/OTHER SURG PROC INCONSISTENT	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow resolution for edit code 740. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's sex.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
742	RECIP AGE/PRINCIPAL SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 74)
743	RECIPIENT AGE/OTHER SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 742. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's age.
746	PRINCIPAL SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	**UB CLAIM:** The system has already paid for the procedure entered (field 74). Verify the procedure code is correct. If there is a correction needed; submit a new claim. If this is a replacement claim (new claim), attach appropriate clinical documentation to the claim for review and consideration for payment. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
747	OTHER SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	Follow the resolution for edit code 746. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) exceeded the frequency limitation.
748	PRINCIPAL SURG PROC REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	**UB CLAIM:** The principal surgical procedure (field 74) requires documentation. Attach appropriate clinical documentation (i.e., discharge summary, operative note, etc.) to the new claim for review and consideration for payment. Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Refer to the appropriate policy manual for specific Medicaid coverage guidelines and documentation requirements.
749	OTHER SURG PROC REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	Follow the resolution for edit code 748. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) requires documentation for manual review.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
750	PRIN SURG PROC NOT COV OR NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	**UB CLAIM:** Check the principal surgical procedure code and date (field 74) to verify their accuracy. Check to see if the principal surgical procedure code is listed on the non-covered surgical procedures list in the appropriate provider policy manual. Check the most recent edition of the ICD-CM manual to be sure the code you are using has not been deleted or changed to another code. If corrections are needed; submit a new claim.
751	OTHER SURG PROC NOT COV/NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Follow the resolution for edit code 750. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is not covered on the date of service.
752	PRINCIPAL SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** For review and consideration for payment, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim which supports the principal surgical procedure (field 74).
753	OTHER SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 752. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is on review.
754	REVENUE CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** The revenue code is invalid. Correct the revenue code (field 42).
755	REVENUE CODE REQUIRES PA/PEND FOR REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** A revenue code (field 42) requires a prior authorization number. Enter the prior authorization number (field 63).
757	OTHER DIAG REQUIRES PA/NO PA NUMBER	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** The other diagnosis (fields 67 A-Q) requires a prior authorization number. Enter the prior authorization number (field 63).
758	PRIM/PRINCIPAL DIAG REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	The primary/principal diagnosis requires documentation. If the primary/principal diagnosis is correct, attach appropriate clinical documentation (i.e., operative report, chart notes, etc.) to the new claim along with the PA letter if prior authorization was obtained for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
759	SEC/OTHER DIAG REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/ notes/summary/report/ chart.	The secondary/other diagnosis requires documentation. Follow the resolution for edit code 758 using the secondary/other diagnosis code.
760	PRIMARY DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Check the current ICD-CM manual to verify that the primary diagnosis is correctly coded and correct date of service was billed. If there are corrections needed; submit a new claim. If the diagnosis code and the date of service are correct, then it is not covered and will not be considered for payment.
761	SEC/OTHER DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	The secondary/other diagnosis code is not covered for the date of service billed. Follow the resolution for edit code 760 using the secondary/other diagnosis code.
762	PRINCIPAL DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The principal diagnosis code (field 67) requires manual review. Attach appropriate clinical documentation (i.e., history, physical, and discharge summary, etc.) to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.
763	OTHER DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 762. The two digits before the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) requires manual review.
764	REVENUE CODE REQUIRES DOC/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The revenue code (field 42) requires manual review. Attach appropriate clinical documentation to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
765	RECIPIENT AGE/REVENUE CODE INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the revenue code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct revenue code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), revenue code (field 42)
766	NEED TO PRICE OP SURG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Verify that the correct procedure code was entered (field 44). If the code is correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
768	ADMIT DIAGNOSIS CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA65 – Missing/incomplete/ invalid admitting diagnosis.	**UB CLAIM:** Verify and correct the admit diagnosis code that was entered on the claim. Medicaid requires the complete diagnosis code as specified in the current edition of the ICD-CM manual, (including fifth digit sub-classification when listed).
769	ASST. SURGEON NOT ALLOWED FOR PROC CODE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Procedure does not allow reimbursement for an assistant surgeon. If the edit appears unjustified or an assistant surgeon was medically necessary due to unforeseen circumstances, attach clinical documentation (i.e., operative report, chart notes, etc.) to the new claim to justify the assistant surgeon. Refer to the applicable provider policy manual for documentation requirements.
771	PROV NOT CERTIFIED TO PERFORM THIS SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Medicaid does not have an FDA certificate on file for the rendering provider. Verify that the procedure code is correctly coded and make corrections to the field(s) below. If applicable, attach the FDA certificate to the new claim. If you are not a certified mammography provider, or a lab provider, this edit code is not correctable. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
773	INAPPROPRIATE PROCEDURE CODE USED	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	Verify that an appropriate procedure code is used and make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
774	LINE ITEM SERV CROSSES STATE FISCAL YEAR	16 – Claim/service lacks information which is needed for adjudication.	N63 – Rebill services on separate claim lines.	Change the units in the field(s) below to reflect days billed on or before 6/30. Add a line to the claim to reflect days billed on or after 07/01. **CMS-1500 CLAIM:** Units (field 24G unshaded)
775	EARLY DELIVERY < 39 WEEKS NOT MEDICALLY NECESSARY	50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.	N180 – This item or service does not meet the criteria for the category under which it was billed.	**CMS 1500 CLAIM:** Verify that the correct procedure code and modifier were billed. For review and consideration for payment, attach appropriate clinical documentation (i.e., medical necessity, entire obstetrical records, radiology, laboratory, and pharmacy records, ACOG Patient Safety Checklist or comparable patient safety justification form, etc.) to the new claim to substantiate the services being billed. Refer to the applicable provider policy manual for documentation requirements.
778	SEC CARRIER PRIOR PAYMENT NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Prior payment for a carrier secondary to Medicaid should not appear on claim. Correct prior payment (field 54).
780	REVENUE CODE REQUIRES PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	**UB CLAIM:** Some revenue codes require a CPT/HCPCS code. Enter the appropriate revenue code (field 42) and CPT/HCPCS code (field 44). A list of revenue codes that require a CPT/HCPCS code is located in Section 4 of the applicable provider manual.
786	ELECTIVE ADMIT,PROC REQ PRE-SURG JUSTIFY	197 – Precertification/ authorization/ notification/ pretreatment absent.		**UB CLAIM:** When type of admission (field 14) is elective, and the procedure requires prior authorization, a prior authorization number from QIO must be entered (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
790	TB RECIP / SERVICE IS NOT TB	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for TB services only. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) and/or modifier to ensure the correct codes were billed. Submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
794	PRINCIPAL MINOR SURGICAL PROCEDURE REQUIRES QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	**UB CLAIM:** Prior authorization is required from QIO. Enter PA number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
795	SURG RATE CLASS/NOT ON FILE-NOT COV DOS	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**UB CLAIM:** Verify that the procedure code (field 44) and date of service (field 45) were entered correctly. If correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
796	PRINC DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** Verify that the diagnosis code (field 67) was submitted correctly. If correct, attach appropriate clinical documentation to support the diagnosis to the new claim for review and consideration for payment.
797	OTHER DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 796. The two digits in front of the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) has not been assigned a level.
798	SURGERY PROCEDURE REQUIRES PA# FROM QIO	A1 – Claim/service denied.	N175 – Missing review organization approval.	A prior authorization from the QIO is required for the surgery procedure billed. Contact the QIO for the authorization number and submit a new claim. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
799	OP PRIN/OTHER PROC REQ QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	Follow the UB claim resolution for edit code 798. The two digits in front of the edit code on the remittance advice identify which principal/other procedure requires QIO prior authorization (field 63).
801	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The provider should review the remittance advice for the procedure codes not allowed on the same date of service. If two or more of the RBHS Community Support Services (CSS) procedure codes were rendered on the same date of service, Medicaid will only reimburse one of the procedures rendered. Submit a new claim with one procedure code rendered, per one date of service, provided that the

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
				clinical documentation supports the service billed. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
802	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/DIFFERENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Medicaid will not reimburse the same or multiple providers for rendering RBHS Community Support Services (CSS) procedure codes on the same day. If another provider was paid for the same or another RBHS CSS for the same date of service, the second billing provider will not be paid. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
808	HEALTH OPPORTUNITY ACCOUNT (HOA) IN DEDUCTIBLE PERIOD	119 – Benefit maximum for this time period or occurrence has been reached.	N435 – Exceeds number/ frequency approved/allowed within time period without support documentation.	Attach supporting documentation to the new claim to indicate the recipient's HOA status and deductible payments for review and consideration for payment.
820	SERVICES REQUIRE ICORE PA - PA MISSING OR NOT ON FILE	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from ICORE prior to rendering the service. No prior authorization number is on the claim or the prior authorization number on the claim is not on file for the recipient. If the prior authorization number is missing, submit a new claim with the prior authorization number provided by ICORE. If a valid prior authorization number is on the claim, contact ICORE for the system to be updated. After ICORE has updated the system, submit a new claim with the valid prior authorization number and attach a copy of the ICORE PA letter for review and consideration for payment. Make corrections to the field(s) below. CMS-1500 CLAIM: Prior authorization number (field 23) Notes: If Medicaid is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If Medicaid is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
821	SERVICES REQUIRE ICORE PA – PA ON CLAIM NOT VALID	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/ invalid treatment authorization code.	Service Requires Prior Authorization from ICORE and the Prior Authorization information on the claim is not valid. Compare the Prior Authorization information received from ICORE to the claim to determine if there are any differences. For example, verify the PA number, check the date(s) of service to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit ICORE has authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the ICORE PA letter, contact ICORE for further assistance. After ICORE has resolved the validity issue, submit a new claim with the valid prior authorization information. **CMS-1500 CLAIM**: Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded). **Notes**: If **Medicaid** is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. If the service is denied, a request must be submitted to ICORE for prior authorization. A new claim with the corrected information must be submitted. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.
837	SERVICE REQUIRES QIO PA–PA MISSING OR NOT ON FILE	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from the QIO prior to rendering the service. No authorization number is on the claim or the authorization number is not on file for the recipient on the claim. If the authorization number is missing, make corrections to the field(s) below. If an authorization number is on the claim, the number needs to be reviewed and updated; contact the QIO. After the QIO has updated the system, submit a new claim. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
				obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
838	SERVICE REQUIRES QIO PA – PA ON CLAIM NOT VALID	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from the QIO and the Prior Authorization on claim is not valid. Compare the Prior Authorization received from the QIO to the claim to determine if there are any differences. For example, verify that the PA number on the claim matches PA number on the QIO letter, check the date(s) of service/date of admission to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the QIO PA letter, attach the QIO PA letter to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded) **UB CLAIM:** Treatment authorization code (field 63), date of admission (field 12), procedure code (field 44 or 74), units (field 46) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
839	IP ADMISSION REQUIRES QIO PA – PA MISSING OR NOT ON FILE	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** IP Admission Requires Prior Authorization (field 63) from the QIO. No prior authorization number on the claim or authorization number is not on file for the recipient. If the authorization number is missing, add it to a new claim and resubmit. If an authorization number is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary **or** the beneficiary has **Medicare PART B ONLY** and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. **For UB claims (Inpatient only):** If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945, Verification of Medicaid Eligibility Letter, to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
843	RTF SERVICES REQUIRE PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** RTF services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
844	IMD SERVICES REQUIRE PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** IMD services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
850	HOME HEALTH VISITS FREQUENCY EXCEEDED	B1 – Non-Covered visits.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The frequency for visits has exceeded the allowed amount and prior authorization is required by the QIO. If there is an error, make the appropriate correction to the claim. Refer to the applicable provider policy manual. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
851	DUP SERVICE, PROVIDER SPEC and DIAGNOSIS	18 – Exact duplicate claim/ service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Verify that the procedure code and the diagnosis code were billed correctly. If incorrect, make corrections to the field(s) below. If correct, the first provider will be paid. The second provider of the same practice specialty will not be reimbursed for services rendered for the same diagnosis. If the 2nd provider should be reviewed and considered for payment, attach appropriate clinical documentation to the new claim which substantiates the services rendered. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
852	DUPLICATE PROV/ SERV FOR DATE OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		1. Review the remittance advice for the duplicate payment date. 2. Check the patient's financial record to see whether payment was received. 3. If two or more of the same procedures were performed on the same date of service and you only received payment for the first date of service, initiate a void to void the original paid claim. Submit a new claim (replacement claim) with the corrected information. 4. If two or more of the same procedures were performed on the same date of service by different individual providers, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the claim for review and consideration for payment. When applicable if two or more of the same procedure were performed on the same date of service and only one procedure was paid, make the appropriate correction to the modifier (field 24D unshaded) on the claim to indicate a repeat procedure. Refer to your manual for applicable repeat modifiers. For further instructions on Void and Replacement claims, refer to Section 3 of the applicable provider policy manual.
853	DUPLICATE SERV/DOS FROM MULTIPLE PROV	B20 – Procedure/ service was partially or fully furnished by another provider.		Medicaid will not reimburse a physician if the procedure was also performed by a laboratory, radiologist, or a cardiologist. If none of the above circumstances apply, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment. Verify that the procedure code (field 24D unshaded on the claim) and date of service (field 24A on the claim) were billed correctly. If incorrect, make the appropriate corrections and submit a new claim. If correct, this indicates that the first provider was paid and additional providers should attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment.
854	VISIT WITHIN SURG PKG TIME LIMITATION	A1 – Claim/service denied.	M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	If the visit is related to the surgery and is the only line on the claim. The visit will not be paid. If the visit is related to the surgery and is on the claim with other payable lines, remove the line with the 854 edit and submit a new claim. This indicates you do not expect payment for this line. If the visit is unrelated to the surgical package, enter the appropriate modifier, 24 or 25, on the new claim (field 24D unshaded).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
855	SURG PROC/PAID VISIT/TIME LIMIT CONFLICT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		If the visit and surgery are related, request recoupment of the visit to pay the surgery. If the visit and surgery are non-related, attach clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim to justify the circumstances for review and consideration of payment.
856	2 PRIM SURGEON BILLING FOR SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Check to see if individual provider number is correct, and the appropriate modifier is used to indicate different operative session, assistant surgeon, surgical team, etc. Make appropriate changes to the field(s) below and submit a new claim. If no modifier is applicable, and field is correct, attach appropriate clinical documentation (i.e., operative notes, etc.) to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded), line provider NPI (field 24J unshaded)
857	DUP LINE – REV CODE, DOS, PROC CODE, MODIFIER	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	**UB CLAIM:** The two-digit number in front of the edit code on the remittance advice identifies which line of field 42 or 44 contains the duplicate code. Make the appropriate correction to the new claim. Duplicate revenue or CPT/HCPCS codes should be combined into one line by deleting the whole duplicate line and adding the units and charges to the other line.
858	TRANSFER TO ANOTHER INSTITUTION DETECTED	B20 –Procedure/ service was partially or fully furnished by another provider.		Check to make sure the dates of service are correct. If there are errors, make the appropriate correction to the new claim.
859	DUPLICATE PROVIDER FOR DATES OF SERVICE	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** Check the remittance advice for the dates of previous payments that conflict with this claim. If this is a duplicate claim or if the additional charges do not change the payment amount, disregard the rejection. If additional services were performed on the same day and will result in a different payment amount, complete a replacement claim (new claim). If services were not done on the same date of service, a new claim should be filed with the correct date of service. Attach clinical documentation (i.e., operative notes, physician orders, etc.) for both the paid claim and new claim(s) explaining the situation.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
860	RECIP SERV FROM MULTI PROV FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** This edit most frequently occurs with a transfer from one hospital to another. One or both of the hospitals entered the wrong "from" or "through" dates (field 6). Verify the date(s) of service. If incorrect, enter the correct dates of service the new claim. If the dates are correct, attach appropriate clinical documentation (i.e., discharge summary, transfer document, ambulance document, etc.) to the new claim for review and consideration for payment. If the claim has a 618 carrier code (field 50), the claim may be duplicating against another provider's Medicare primary inpatient or outpatient claim, or against the provider's own Medicare primary inpatient or outpatient claim. If either situation occurs, attach the Medicare EOMB to the new claim for review and consideration for payment.
863	DUPLICATE PROV/SERV FOR DATES OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, disregard the rejection. Submit a new claim, if it will result in a different payment amount. **Note:** Payment changes usually occurs when there is a change in the inpatient DRG or reimbursement type, or a change in the outpatient reimbursement type.
865	DUP PROC/SAME DOS/DIFF ANES MOD	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		You have been paid for this procedure with a different modifier. Verify by the anesthesia record the correct modifier. Make appropriate corrections, if applicable, and submit a new claim. If the paid claim is correct, discard the rejection. If this procedure should be paid, attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)
866	NURS HOME CLAIM DATES OF SERVICE OVERLAP	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, discard the claim. Submit a new DHHS Form 181 with monthly billing, if it will result in a different payment amount and different dates of service.
867	DUPLICATE ADJ - ORIGINAL CLM ALRDY VOIDED	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Provider has submitted an adjustment claim for an original claim that has already been voided. An adjustment cannot be made on a previously voided claim. Discard the claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
877	SURGICAL PROCS ON SEPERATE CLMS/SAME DOS	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		This edit indicates payment has been made for a primary surgical procedure at 100%. The system has identified that another surgical procedure for the same date of service was paid after manual pricing and approval. This indicates a review is necessary to ensure correct payment of the submitted claim. Make corrections to the claim by entering appropriate modifiers to indicate different operative sessions, assistant surgeon, surgical team, etc., and attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A unshaded)
883	CARE CALL SERVICE BILLED OUTSIDE THE CARE CALL SYSTEM	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	This edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
884	OVERLAPPING PROCEDURES (SERVICES) SAME DOS/SAME PROVIDER	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. Check the patient's financial records to see whether payment was received. If payment was received, discard the rejection. If the claim/service is incorrect, void the claim and submit a new claim with the corrected information. If the procedures (services) overlap, attach appropriate clinical documentation to the new claim to substantiate the services being billed for review and consideration for payment.
885	PROVIDER BILLED AS ASST and PRIMARY SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Verify which surgeon was primary and which was the assistant. Check the individual provider number. The modifier may need correcting to indicate different operative sessions, surgical team, etc. Attach applicable clinical documentation to the new claim for review and consideration for payment, if applicable, to determine which surgeon was primary and which was the assistant surgeon. If you have been paid incorrectly as a primary and/or assistant surgeon, void the paid claim and submit a new claim with the corrected information. Make appropriate corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded), modifier (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
887	PROV SUBMITTING MULT CLAIMS FOR SURGERY	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., Medicare EOB, sterilization consent forms, etc.), and remittance advice from original claim to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the modifier 78 or 79 (field 24D unshaded) on the new claim.
888	DUP DATES OF SERVICE FOR EXTENDED NH CLM	B13 – Previously Paid. Payment for this claim/ service may have been provided in a previous payment.		Check your records to see if this claim has been paid. If this is a duplicate claim, disregard the rejection. If dates of service are different or payment amount is different, submit a corrected DHHS Form 181 and EOMB with a new claim.
889	PROVIDER PREVIOUSLY PD AS AN ASST SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**CMS 1500 CLAIM:** Verify which surgeon was primary and which was the assistant. If the surgeon has been paid as the assistant, and was the primary surgeon, void the paid claim and submit a new claim with the corrected information. If a review is needed, attach applicable clinical documentation (i.e., operative notes, surgical team, etc.) to the new claim for review and consideration for payment.
892	DUP DATE OF SERVICE,PROC/MOD ON SAME CLM	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	If duplicate services were not provided, delete the duplicate line from the claim. If duplicate services were provided and the correct duplicate modifier was billed, attach support clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded) **Note**: If reimbursement is for an assistant surgeon OR multiple births**;** use the Modifier (GB or CG) on the applicable lines(s).
893	CONFLICTING AA/QK MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with AA modifier and one with QK/QY modifier. Verify the correct modifier and/or procedure code for the date of service by the anesthesia record. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
894	CONFLICTING QX/QZ MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with QX modifier and one with QZ modifier. Verify by the anesthesia record if the procedure was rendered by a supervised or independent CRNA. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
895	CONFLICTING AA and QX/QZ MOD SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims have been submitted by an anesthesiologist as personally performed anesthesia services and a CRNA has also submitted a claim. Verify by the anesthesia record the correct modifier for the procedure code on the date of service. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
897	MULT. SURGERIES ON CONFLICTING CLM/DOS	59 – Processed based on multiple or concurrent procedure rules.		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., operative note and remittance from original claim, etc.) to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the correct modifier 78 or 79 (field 24D unshaded) on the new claim.
899	CONFLICTING QK/QZ MOD FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Verify by the anesthesia record the correct modifier and procedure code for the date of service. If this procedure was rendered by an anesthesia team, the supervising physician should bill with QK modifier and the supervised CRNA should bill with the QX modifier. The QY modifier indicates the physician was supervising a single procedure. Attach applicable clinical documentation to the new claim for review and consideration for payment. Refer to the applicable policy manual for clinical documentation guidelines. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
900	PROVIDER ID IS NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the provider ID number on the claim is correct. Make the appropriate correction to the new claim For assistance, contact Provider Enrollment at 1-888-289-0709.
901	INDIVIDUAL PROVIDER ID NUM NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the individual provider ID number is correct. Submit a new claim with the corrected information. For assistance, contact Provider Enrollment at 1-888-289-0709. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded),
902	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Pay-to-provider was not eligible for date of service or was not enrolled when service was rendered. Verify whether the date of service on claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
903	INDIV PROVIDER INELIGIBLE ON DTE OF SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
904	PROVIDER SUSPENDED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. If not, correct and submit a new claim. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.
905	INDIVIDUAL PROVIDER SUSPENDED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 904.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
906	PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	Provider is on Prepayment Review. All claims must be submitted with documentation attached to substantiate the billed service. See document requirements outlined in the applicable provider policy manual. In some instances the provider may be required to submit paper claims. Refer to the Provider Prepayment Claims Review Notice. If you have not yet received notice or have questions regarding the notice, contact Program Integrity at 803-898-2640.
907	INDIVIDUAL PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	Provider is on Prepayment Review. All claims must be submitted with documentation attached to substantiate the billed service. See document requirements outlined in the applicable provider policy manual. In some instances the provider may be required to submit paper claims. Refer to the Provider Prepayment Claims Review Notice. If you have not yet received notice or have questions regarding the notice, contact Program Integrity at 803-898-2640.
908	PROVIDER TERMINATED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903
909	INDIVIDUAL PROVIDER TERMINATED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903.
911	INDIV PROV NOT MEMBER OF BILLING GROUP	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify whether the provider number entered (field 24J) on the claim is correct. If incorrect, submit a new claim with the corrected information. If the provider number is correct, contact Provider Enrollment at 1-888-289-0709 to have the individual provider number added to the billing group ID number. After the system has been updated, submit a new claim.
912	PROV REQUIRES PA/NO PA NUMBER ON CLAIM	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
914	INDIV PROV REQUIRES PA/NO PA NUM ON CLM	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
915	GROUP PROV ID/NO INDIV ID ON CLAIM/LINE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify the rendering individual physician and enter his or her provider ID number in the field(s) below and submit a new claim. **CMS-1500 CLAIM:** Provider ID number (field 24J)
916	CRD PRIM DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct primary diagnosis code (field 21) on the new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
917	CRD SEC DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 916 according to the secondary diagnosis code.
918	CRD PROCEDURE CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct procedure code (field 24D unshaded) and submit a new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
919	NO PA# ON CLM/PROV OUT OF 25 MILE RADIUS	40 – Charges do not meet qualifications for emergent/urgent care.		Prior authorization approval is required for services outside of the SC Medicaid service area. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
920	Transportation Service is covered by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The transportation service is covered by a Contractual Transportation Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
921	Ambulance service is payable by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The ambulance service is covered by a Contractual Ambulance Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
922	URGENT SERVICE/OOS PROVIDER	133 – The disposition of the claim/service is pending further review.		Verify the urgent service/out-of-state provider requirements were followed. Attach the appropriate clinical documentation to the new claim for review and consideration for payment.
923	PROVIDER TYPE / CAT. INCONSIST W/ LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		Verify that the provider information, procedure code and level of care are correct. If there are errors, submit a new claim with the corrected information. Refer to the applicable provider manual for appropriate provider type and level of care.
924	RCF PROV/RECIP PAY CAT NOT 85 OR 86	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the recipient's eligibility to verify the payment category for the date of service that was rendered. If there are errors, submit a new claim with corrected DHHS CRCF-01 Form with the monthly billing and other applicable documentation. If the recipient's payment category has been updated to 85 or 86, submit a new claim with the DHHS CRCF-01 Form with the monthly billing.
925	AGES > 21 &< 65 / IMD HOSPITAL NON-COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-64. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.
926	AGE 21-22/MENTAL INST SERV N/C - MAN REV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-22. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
927	PROVIDER NOT AUTHORIZED AS HOSPICE PROV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider was not authorized or enrolled as a hospice provider when service was rendered and will not be considered for payment. For provider's enrollment or eligibility status, contact Provider Enrollment at 1-888-289-0709.
928	RECIP UNDER 21/HOSP SERVICE REQUIRES PA	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	**UB CLAIM:** No authorization number from the referring state agency is on the claim. Make the appropriate correction and submit a new claim. Attach appropriate clinical documentation to the new claim for review and consideration for payment, if applicable.
929	NON QMB RECIPIENT	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Provider is Medicare only provider attempting to bill for a non-QMB (Medicaid only) recipient. Medicaid does not provide reimbursement to QMB providers for non-QMB recipients.
932	PAY TO PROV NOT GROUP/LINE PROV NOT SAME	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify and correct the provider ID and/or NPI to ensure it is the same as the Provider ID and/or NPI on the line(s). Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 24J) NPI (field 33 A & B)
933	REV CODE 172 OR 175/NO NICU RATE ON FILE	147 – Provider contracted/ negotiated rate expired or not on file.		**UB CLAIM:** Verify the correct revenue code (field 42) was billed. If the revenue code is incorrect, make the appropriate correction to the new claim. If the provider was not contracted when the service was rendered, the negotiated rate expired, or the codes were not on file, the edit is valid and will not be considered for payment.
934	PRIOR AUTHORIZATION NH PROV ID NOT AUTHORIZED	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Enter the correct Nursing Facility Provider number in the Prior Authorization field(s) below. **CMS-1500 CLAIM:** Prior Authorization (field 23)
935	PROVIDER WILL NOT ACCEPT TITLE 18 (MEDICARE) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is dually eligible. Services can only be billed for beneficiaries who are Medicaid only. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
936	NON EMERGENCY SERVICE/OOS PROVIDER	40 – Charges do not meet qualifications for emergent/urgent care.		**UB CLAIM:** If diagnosis code (field 67) and surgical procedure codes (field 44 or 74) have been coded correctly, this outpatient service is not covered for out-of-state providers. No payment is due from Medicaid.
938	PROV WILL NOT ACCEPT TITLE 19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
939	IND PROV WILL NOT ACCEPT T-19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
940	BILLING PROV NOT RECIP IPC PHYSICIAN	170 - Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Contact that recipient's IPC physician to obtain the authorization for the service. Submit the IPC/OSCAP authorization form or IPC/OSCAP termination form with the monthly billing.
941	NPI ON CLAIM NOT FOUND ON PROVIDER FILE	208 – National Provider Identifier – Not matched.		Check the NPI that was entered on the claim to ensure it is correct. If correct, register the NPI with Provider Enrollment. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
942	INVALID NPI	207 – National Provider Identifier – invalid format.	N257 – Missing/incomplete/ invalid billing provider/supplier primary identifier.	The NPI used on the claim is inconsistent with numbering scheme utilized by NPPES. Submit a new claim with the corrected information.
943	TYPICAL PROVIDER, NO NPI ON CLAIM	206 – National Provider Identifier – missing.		Typical providers must use the NPI and six-character Medicaid Legacy Provider Number or NPI only for each rendering and billing/pay-to provider. When billing with NPI only, the taxonomy code for each rendering and billing/pay-to provider must also be included. Submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
944	TAXONOMY ON CLAIM HAS NOT BEEN REGISTERED WITH PROVIDER ENROLLMENT FOR THE NPI USED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Correct the taxonomy on the claim so that it is one that the provider registered with SCDHHS the claim or contact Provider Enrollment to add the taxonomy that is being used on the claim. Once Provider Enrollment has updated the system, submit a new claim. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
945	PROFESSIONAL COMPONENT REQUIRED FOR PROV	A1 – Claim/service denied.	N13 – Payment based on professional/technical component modifier(s).	The services were rendered on an inpatient or outpatient basis. Enter a "26" modifier in field(s) below. Services described in this manual do not require a modifier. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
946	UNABLE TO CROSSWALK TO LEGACY PROVIDER NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	The NPI, taxonomy code, and/or zip code + 4 must be entered on the claim and must match the NPI information that the provider registered with SC Medicaid. Submit a new claim with the corrected information. Contact Provider Enrollment at 1-888-289-0709 to verify the NPI information which was registered or to make any updates to the NPI information contained on the provider's file.
947	ATYPICAL PROVIDER AND NPI UTILIZED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Atypical providers must continue to use their legacy number on the claim. Do not include an NPI if you are an atypical provider. Submit a new claim with the corrected information
948	CONTRACT RATE NOT ON FILE/SERV NC ON DOS	147 – Provider contracted/negotiated rate expired or not on file.		Review your contract to verify if the correct procedure code/rate and date of service were billed. Submit a new claim with the corrected information. If the procedure code/rate needs to be added, attach appropriate documentation to the claim for review and consideration for payment.
949	CONTRACT NOT ON FILE FOR ELECTRONIC CLAIMS	A1 – Claim/service denied.	N51 — Electronic interchange agreement not on file for provider/submitter.	Contact the EDI Support Center at 1-888-289-0709 for further assistance.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
950	RECIPIENT ID NUMBER NOT ON FILE	31 – Patient cannot be identified as our insured.		Check the patient's Medicaid ID number to make sure it was entered correctly. Remember, the patient's Medicaid numbers is 10 digits (no alpha characters). If there is a discrepancy with the patient's Medicaid ID number, contact the Medicaid Eligibility office in the patient's county of residence to correct the number on the patient's file. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
951	RECIPIENT INELIGIBLE ON DATES OF SERVICE	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Always check the patient's Medicaid eligibility on each date of service. Medicaid eligibility may change. If the patient was eligible, contact your county Medicaid Eligibility office and have them update the patient's Medicaid eligibility on the system. After the county Medicaid Eligibility office has updated, submit a new claim. If the patient was not eligible for Medicaid on the date of service, the patient is responsible for your charges. If the patient was eligible for some but not all of your charges, submit a new claim with the corrected information.
952	RECIPIENT PREPAYMENT REVIEW REQUIRED	16 – Claim/service lacks information or has submission/billing error(s).	M62 – Missing/incomplete/invalid treatment authorization code.	Verify the correct prior authorization number. If the authorization number is incorrect, make the appropriate correction to the new claim. Attach appropriate documentation to the new claim for review and consideration for payment, if applicable.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
953	BUYIN INDICATED - POSSIBLE MEDICARE	22 - This care may be covered by another payer per coordination of benefits.		File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in field(s) below and submit a new claim. If no payment was made, on the new claim, enter '1' in the TPL field. **CMS-1500 CLAIM:** Medicare carrier code (field 9D & 11C), Medicare number (field 9A & 11), Medicare payment (fields 9C,11B & 29), and TPL indicator (field 10 D) **UB CLAIM:** (Inpatient/Outpatient): Medicare carrier code (field 50), Medicare number (field 60), and Medicare payment (field 54). If no payment was made, enter 0.00 (field 54) and occurrence code 24 or 25 (fields 31-34 A-B) and the date Medicare denied. **UB CLAIM:** (Inpatient Only): Attach the Medicare EOMB to the claim, if Medicare (Part A) benefits are exhausted or non-existent, prior to admission and patient is still in the same spell of illness, enter the 620 carrier code (field 50), enter the Medicare ancillary payment(s) (field 54 A) and enter the recipient's Medicare ID (field 60 A) the claim with the corrected information. Click here for additional resolutions tips at MedicaideLearning.com.
957	DIALYSIS PROC CODE/PAT NOT CIS ENROLLED	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	Attach the ESRD enrollment form (Form 218) for the first date of service to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.
958	IPC DAYS EXCEEDED OR NOT AUTH ON DOS	273 – Coverage/ program guidelines were exceeded.		Integrated Personal Care services/OSCAP are authorized with start and end dates of service. If the start and end dates of service are incorrect, submit a new IPC/OSCAP form with the corrected information on the new claim. If correct, attach a copy of the service provision form and/or any applicable DHHS forms to the new claim for review and consideration for payment. Please refer to the applicable policy manual for documentation submission guidelines
960	EXCEEDS ESRD M'CARE 90 DAY ENROLL PERIOD	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	For review and consideration for payment, attach the denial letter or document from the Social Security Administration (SSA) and Medicare letter denying benefits to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
964	FFS CLAIM FOR SLMB/QDWI RECIP NOT CVRD	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Medicaid pays Medicare premiums only for recipients in these Medicaid payment categories. Fee-for-service Medicaid claims are not reimbursed.
965	PCCM RECIP/PROV NOT PCP-PROC REQ REFERAL	243 - Services not authorized by network/ primary care providers.	N95 – This provider type/provider specialty may not bill this service.	Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Enter the authorization number provided by the PCP in the field(s) below and submit the new claim. **CMS-1500 CLAIM:** (field 19) **UB CLAIM:** Treatment authorization code (field 63)
966	RECIP NOT ELIG FOR VENT WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The claim was submitted with a Mechanical Ventilator Dependent Waiver (MVDW) specific procedure code, but the patient was not a participant in the MVDW. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). Make the appropriate corrections on the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and a MVDW form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
967	RECIP NOT ELIG FOR HD and SPINAL SERVICES	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a Head and Spinal Cord Injured (HASCI) waiver-specific procedure code, but the patient was not a participant in the HASCI waiver. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and the HASCI waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
970	HOSPICE SERV/RECIP NOT ENROLLED FOR DOS	96 – Non-covered charges.	N143 – The patient was not in a hospice program during all or part of the service dates billed.	Service is hospice. Recipient is not enrolled in hospice for the date of service.
974	RECIP IN MCO/MCO COVERS FIRST 90 DAYS	24 – Charges are covered under a capitation agreement/ managed care plan.		If you are a provider with the MCO plan, bill the MCO for the first 90 days.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
975	PACE PARTICIPANT/ALL SERVICES PROVIDED BY PACE	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/billing/payment information related to these charges.	Contact recipient's PACE organization.
976	HOSPICE RECIPIENT/ SERVICE REQUIRES PA	B9 – Patient is enrolled in a Hospice.		Use the SCDHHS Web Tool to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in the field(s) below and submit a new claim. **CMS 1500 CLAIM:** Prior authorization number/MHN referral Number (field 19) **UB CLAIM:** Prior authorization number (field 63)
977	FREQUENCY FOR AMBULATORY VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Medicaid recipients are allowed 12 ambulatory care visits per year. The ambulatory care visits for this recipient have been exhausted. Verifying the availability of the recipient's ambulatory care visits on the date of service being billed or the day before will reflect the estimated visits remaining at the time of service, but should not be considered a guarantee of payment. Please refer to the Ambulatory Care Visit Guidelines in the applicable provider manual for more information. All timely filing requirements must be met. Provider options: Submit a request to Medicaid for additional ambulatory care visit(s), including appropriate documentation stating the medical reason(s) for the request. Once the authorization is obtained, submit a new claim along with the SCDHHS approval letter, **or** Bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc., done in addition to the office visit, **or** Change the office visit code to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory care visit limit. Exceptions to the 977 edit: Medicaid recipients residing in a nursing home or long-term care facility are exempt from the ACV limit of 12 visits. This applies to claims with a place of service of 31, 32, 33 and 54. A new claim must be submitted within six months of the rejection with a copy of verification of coverage attached indicating ambulatory care visits were available for the date of service being billed. The availability of

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
				ambulatory visits must have been verified on the actual date of service being billed or the day before. If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory care visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. All timely filing requirements must be met.
978	FREQUENCY FOR IP HOSPITAL VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		**UB CLAIM:** The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. If correct, for review and consideration for payment of additional visits, attach appropriate clinical documentation to the new claim to substantiate the services being billed.
979	FREQ. FOR CHIROPRACTIC VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. **CMS-1500 CLAIM:** Unit(s) (field 24G)
980	H HLTH NURS CARE N/C FOR DUAL ELIG RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	File your claim with the Medicare intermediary.
984	RECIP LIVING ARR INDICATES MEDICAL FAC	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Verify patient's place of residence on date of service. If there are errors, submit a new claim with the corrected information. If correct, for review and consideration for payment, attach applicable documentation (i.e., insurance EOB) to the new claim which verifies the place of residence.
985	RECIP NOT ELIG FOR CHILDREN'S PCA SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check to make sure you have billed the correct Medicaid ID number, procedure code and that this client is in the CHPC program. If you have not billed the correct Medicaid ID number or procedure code, or the client is not in the CHPC program, submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
987	RECIP NOT ELIG FOR HIV/AIDS WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a HIV/AIDS Waiver-specific procedure code, but the patient was not a participant in the HIV/AIDS Waiver. Check the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid number is correct, the procedure code is correct, and a HIV/AIDS Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
988	CRD PROCEDURE/DOS PRIOR TO COVERAGE	26 – Expenses incurred prior to coverage.	N30 – Patient ineligible for this service.	Call PSC representative to see what the recipient's first date of treatment is. If dates of service on the claim are prior to enrollment date, verify enrollment date. If enrollment date is correct, change dates on the new claim If enrollment date is wrong, the recipient's file will need to be updated. Attach a new enrollment form (DHHS Form 218) to the new claim
989	RECIP IN MCO/SERV COVERED BY MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		Recipient is enrolled with a Managed Care Organization (MCO), the MCO is responsible for management of this recipient's medical services. If you are a provider with the MCO, bill the MCO for the medical service. Discard the rejection. SCDHHS Fee for Service (FFS) Medicaid is not responsible for claim payment for this recipient. **UB CLAIM Only:** Attach EOB denial from the MCO, to the **NEW** claim for review and consideration for payment. Click here for additional resolution tips at MedicaideLearning.com.
990	FP RECIP/SERVICE IS NOT FP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Make sure the Medicaid ID number matches the patient served. Check the diagnosis code(s), procedure code(s), and/or modifier to ensure the correct codes were billed. If incorrect, make the appropriate changes by adding a family planning diagnosis code, procedure code, and/or FP modifier to the new claim. If this service was not directly related to family planning it is non-covered under the Family Planning Waiver and by Medicaid, therefore the patient is responsible for the charges. Click here for additional resolution tips at MedicaideLearning.com.
991	RECIP ISCEDC/COSY-LIMITED SERVS. COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Limited services are covered for this recipient. This is not a covered service.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
993	RECIP NOT ELIG FOR PACE SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient was not eligible for PACE when the service was rendered. Verify that the information on the claim is correct. If not correct, submit a new claim with the corrected information. If the recipient's PACE eligibility status has been updated in the system, submit a new claim.
994	RECIP ELIG FOR EMERGENCY SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for "emergency medical services" only. Transportation services and/or any other non-emergent medical services are non-covered for these recipients and will not be considered for payment.
995	INMATE RECIP ELIG FOR INSTIT. SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient eligible for institutional services only. Review the claim to determine if the services were directly related to institutional services. If there are errors, submit a new claim with the corrected information. If the services are not directly related to institutional services, the services are non-covered and will not be considered for payment. **UB CLAIM:** Only inpatient claims will be reimbursed.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

Effective 01/01/19

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
CO5							
700							
X1T							
C53							
X2C							
X21							
X20							
X2D							
C67							
X25							
C69							
X2E							
X2Q							
A60							
X1Z							
X2N							
C23							
X2I							
X2R							
102							
X0G							
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	6464739200	
462	1ST MEDICAL NETWORK	PO BOX 724317	ATLANTA	GA	31139	8889806676	CODE ASSIGNED BY SCHA
710	21ST CENTURY HEALTH AND BENEFITS, INC.	PO BOX 5037	CHERRY HILL	NJ	08034	8003234890	
F27	3PADMINISTRATORS	PO BOX 247	ONALASKA	WI	54650	6087793000	DENTAL ONLY
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	DENTAL ONLY
650	ABBEVILLE COUNTY						
543	ACHA/CAREINGTON INTERNATIONAL CORP	PO BOX 2568	FRISCO	TX	75034	8002900523	CODE ASSIGNED BY SCHA
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	8002326242	
786	ACS BENEFIT SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	8008495370	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C49	ACS CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008495370	WAS PENN WESTERN
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	6024689500	
341	ADMINISTRATIVE CONCEPTS, INC.	994 OLD EAGLE SCHOOL RD., STE. 1005	WAYNE	PA	19087	8882939229	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG. D	BROADVIEW HEIGHTS	OH	44147		
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLDG #9	TUCKER	GA	30084	7709343953	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	6783390211	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	8664704959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	4803914600	SEE CARRIER 471
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	8884191094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	8007425246	
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR., STE. 2000	LITTLE ROCK	AR	72211	8882424800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	8007135095	MEDICARE ADVANTAGE PLAN
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	8006380589	
899	AETNA HEALTH PLANS OF THE CAROLINAS, INC.	3 CENTERVIEW DR.	GREENSBORO	NC	27407	8004591466	HMO PLAN ONLY
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	8004233289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	8006240756	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
100RX	AETNA PHARMACY	PO BOX 52444	PHOENIX	AZ	850722444	8002386279	
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	8003334432	
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	8004517715	
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	8662475678	
776	AFID (ASSO. OF FRANCHISE AND INDEPENDENT DIST.)	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE IN OPEN STATUS BY SCHA
595	AFLAC-AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	8009923522	
289	AFTRA HEALTH FUND	261 MADISON AVE.	NEW YORK	NY	10016	8005624690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E55	AG ADMINISTRATORS	PO BOX 979	VALLEY FORGE	PA	19482	8006348628	
651	AIKEN COUNTY						
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE., STE. 107	ANCHORAGE	AK	995034116	8004784450	CODE ASSIGNED BY SCHA
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	8008825707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	2125395115	
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	7733996645	
199	ALL OTHER CARRIERS						
F54	ALLEGIANCE	PO BOX 3018	MISSOULA	MT	59806	8559992271	ADDED BY SC REVENUE AND FISCAL AFFAIRS
E54	ALLEGIANCE BENEFIT PLAN MANAGEMENT	PO BOX 3018	MISSOULA	MT	598063018	8008771122	
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	8008255406	
652	ALLENDALE COUNTY						
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	8003423289	
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	8002350123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	8002834927	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786-60690	CHICAGO	IL	606909786	8002882078	
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	8008257531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	8003668997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	8009377039	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	8009985033	
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD., STE. 106	ATLANTA	GA	30341	8002417319	
E44	ALTERNATIVE INSURANCE RESOURCE, INC.	PO BOX 680787	BIRMINGHAM	AL	352660787	8004514318	
B96	ALTERNATIVE RISK MANAGEMENTS (ARM LTD)	814 N.W. HIGHWAY	ARLINGTON HEIGHTS	IL	60004	8003921770	
234	ALWAYSCARE BENEFITS, INC.	PO BOX 80139	BATON ROUGE	LA	70898	8887295433	DENTAL PLAN
161	AMA INSURANCE AGENCY, INC.	PO BOX 804238	CHICAGO	IL	60680	8004585736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	2124735700	
F57	AMBETTER PEACH STATE HEALTH PLAN	PO BOX 5010	FARMINGTON	MD	636405010	8776871180	ADDED BY SC REVENUE AND FISCAL AFFAIRS
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	8007867930	
309	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	6304939252	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	8003545112	WAS GALLAGER & BASSETT SERVICES
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	8005235880	
B61	AMERICAN BEHAVIORAL	3680 GRANDVIEW PARKWAY STE. 100	BIRMINGHAM	AL	35243	8009258327	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	6304161111	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	2200-B ROSSELLE ST.	JACKSONVILLE	FL	32204	8004685126	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE. NORTHWEST	NORTH CANTON	OH	44720	3309665500	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	8006334226	
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	8005989799	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	8004331672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
778	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 14770	LEXINGTON	KY	40512	8002644000	
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	6153371300	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	8006548489	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	8008882452	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NE	89109	8008424742	
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NV	89109	8008424742	CODE ASSIGNED BY SCHA
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	3013323000	
C92	AMERICAN HEALTH CARE	3850 ATHERTON RD.	ROCKLIN	CA	95765	8008728276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST.	ROSEVILLE	CA	95661	8008728276	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	8008728276	
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	8772840102	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	8005358086	
840	AMERICAN, INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	8177723050	
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	8009221245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	8009221245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	8004687077	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 26050	OVERLAND PARK	KS	66225	8887221668	
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	8882641512	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREEN BAY	WI	543079032	8002325432	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	8008996803	
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	8005381053	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	8002222798	
321DN	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 1358	GLEN BURNIE	MD	21060	8002222798	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	8006268913	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	8002568606	
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	8002472190	
C70	AMERICAN RETIREMENT LIFE	PO BOX 30010	AUSTIN	TX	757553010	8664591755	REQUESTED BY THE SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	8006927338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD., BLDG. TWO	MOORESTOWN	NJ	08057	8003597475	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	PO DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	4052334000	CODE IN OPEN STATUS BY SCHA
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	8772926037	
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	2152441600	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	9134514900	
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	8006216360	
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	8663213947	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	8003089823	MEDICARE ADVANTAGE PLAN
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	8666994186	
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	8006004441	CODE ASSIGNED BY SCHA
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	8003454017	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	8886323862	CODE ASSIGNED BY SCHA
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	8889917200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A10	AMERISCRIPT	4301 DARROW RD., STE. 4200	STOW	OH	44224	8006816912	
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	8002559678	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	39236	8888882519	
653	ANDERSON COUNTY						
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	2147200511	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	8005529159	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	8006224822	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	8006224822	
529	ANTHEM HEALTH	3575 KROGER BLVD., STE. 400	DULUTH	GA	30316	8008881966	
579	ANTHEM PRESCRIPTION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	8006620210	USE CARRIER A24
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	8882909160	MEDICARE ADVANTAGE PLAN
171	AON	PO BOX 66	WINSTON-SALEM	NC	27102	8003683804	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	8008333650	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	8002218699	
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	8007756490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	8005227487	
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHOENIX	AZ	850622909	6022318855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.	PO BOX 2181	LITTLE ROCK	AR	72203	5013782010	
B78	ARM GROUP (OMNICARE)	340 QUADRANGLE DR.	BOLINGBROOK	IL	60440	8009687222	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49516	8009682449	
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	8006382972	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
934	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
458	ASSOCIATION BENEFIT PLAN (MEDICARE)	PO BOX 668587	CHARLOTTE	NC	282668587	8006340069	CODE ASSIGNED BY SCHA
386	ASSURANT HEALTH	PO BOX 624	MILWAUKEE	WI	532010624	MILWAUKEE	WAS FORTIS INSURANCE COMPANY
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	527332940	8004427742	DHHS INTERNAL RECOVERY CLAIMS BILLING MUST BE FAX TO: 414-224-0472
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	8005537654	CODE ASSIGNED BY SCHA
451	ASSURECARE RISK MANAGEMENT	340 QUADRANGLE BLVD.	BOLINGBROOK	IL	60440	8007597422	
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	8646091000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	8005481256	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	4046592100	
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	8437638680	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	8883282287	
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	8003448858	
588	AUTOMATED BENEFIT SERVICES, INC.	PO BOX 321223	DETROIT	MI	482321223	8002751896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B82	AVANTE HEALTH	1111 E. HERNDON AVE., STE. 308	FRESNO	CA	93720	8664163617	
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	8883222115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST., STE. 300	PHOENIX	AZ	85012	6022413400	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	8004528633	
A72	BABB, INC.	850 RIDGE AVE.	PITTSBURGH	PA	15212	8002456102	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE., STE. 300	KENSINGTON	MD	208953960	3014683742	
654	BAMBERG COUNTY						
987	BANKERS FIDELITY LIFE INS CO	PO BOX 105652	ATLANTA	GA	30348	4042665500	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANO	TX	75026	8664587499	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	8006213724	
655	BARNWELL COUNTY						
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	8004412273	MEDICARE INTERMEDIARY
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 659444	SAN ANTONIO	TX	78265	4048428000	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	8002535210	DENTAL ONLY
867	BCBS OF NC	PO BOX 30087	DURHAM	NC	27702	9194897431	
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
643	BCBS OF TENNESSEE	730 CHESTNUT ST.	CHATTANOOGA	TN	37402	8772966189	MEDICARE INTERMEDIARY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
656	BEAUFORT COUNTY						
881	BEHAVIORAL HEALTH SYSTEMS	PO BOX 830724	BIRMINGHAM	AL	352830724	8002451150	
C08	BENECARD	PO BOX 2187	CLIFTON	NJ	07015	8007379528	
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	8159699663	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR., STE. 1B	HOMEWOOD	IL	60430	7087997400	
E87	BENEFIT ADMINISTRATIVE SYSTEMS	PO BOX 2920	MILWAUKEE	WI	53201	8005250582	
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	8778400936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	8003258424	
300	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
300DN	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	3045621913	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	8002202600	
F29DN	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	DENTAL
F29	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	8002629175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C12	BENEFIT MANAGEMENT, INC.	PO BOX 1090	GREAT BEND	KS	66210	8002901368	
301	BENEFIT PLAN ADMINISTRATORS	PO BOX 21392	EAGEN	MN	55121	8002778973	
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	8776427500	
311	BENEFIT PLANNERS, INC.	PO BOX 682010	SAN ANTONIO	TX	78269	2106991872	
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINESVILLE	GA	30503	8007774782	
772	BENEFIT SYSTEMS, INC.	PO BOX 6001	INDIANAPOLIS	IN	462066001	8008243216	
127	BENEFITSOURCE, INC.	PO BOX 240	MONROE	MI	48161	8004231028	CODE ASSIGNED BY SCHA
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE.	GREENWOOD VILLAGE	CO	80111	8003453189	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	8003621116	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	3372341789	
256	BENICOMP	8310 CLINTON PARK DR.	FT. WAYNE	IN	46825	8008377400	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	6013660596	
481	BENOVATION	3481 CENTRAL PARKWAY, STE. 200	CINCINNATI	OH	45223	8006816912	CODE ASSIGNED BY SCHA
657	BERKELEY COUNTY						
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	8008674446	
E29	BEST LIFE AND HEALTH INSURANCE CO.	PO BOX 890	MERIDIAN	ID	836800890	8004330088	
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	8772542363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	8007764672	
902	BLUE CARE NETWORK OF MI	PO BOX 68710	GRAND RAPID	MI	49516	8006588878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICARE ADVANTAGE (PPO)
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	8037868466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICAID HMO
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	3154483801	
X2W	BLUE CROSS & BLUE SHIELD OF ARIZONA, INC.	PO BOX 13466	PHOENIX	AZ	850023466	6028644100	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BROADWAY	DENVER	CO	80273	3038312131	
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT, INC.	PO BOX 533	NORTH HAVEN	CT	06473	2032394961	
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE, INC.	PO BOX 1991	WILMINGTON	DE	19899	3024210260	
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA, INC.	PO BOX 9907	COLUMBUS	GA	319086007	4048428000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	7852914180	
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	8008926048	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY, INC.	9901 LINN STATION RD.	LOUISVILLE	KY	40223	5024232011	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	5042915370	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	2077751550	
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	40512	8005244555	
X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	8005244555	USE CARRIER X01
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD.	MEMPHIS	TN	38103	9015293111	
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 312500	DETROIT	MI	48231	8004820898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	8888268152	
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST. PAUL	MN	55164	8003822000	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC.	PO BOX 1043	JACKSON	MS	39215	6016644590	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST. LOUIS	MO	63103	3149234444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN PO STATION	OMAHA	NE	681800001	4023901820	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1219	NEWARK	NJ	07101	8006241110	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1311	MINNEAPOLIS	MN	55440	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	8002144844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON-SALEM	NC	271022100	9194897431	
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	8003682312	
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	9185603535	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	4018317300	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	8004689736	
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	8005659140	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	8013332100	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	3157984238	
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 2365	SOUTH BURLINGTON	VT	54072365	8022472583	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	8009916061	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA, INC.	PO BOX 1353	CHARLESTON	WV	25325	3043477709	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	8008880757	
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	4142246100	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	2024798000	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35201	8005176425	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 830389	BIRMINGHAM	AL	352830389	8005176425	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	8007272227	
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	8037883860	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. STREET ADDRESS 4101 CERVICAL RD. COLA 29219
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8037883860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	8004510287	
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	8004947218	
X2FDN	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	7163253630	DENTAL
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	8006762583	MEDICARE ADVANTAGE PLAN
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	4067914000	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	8007113795	
X1FDN	BLUE CROSS BLUE SHIELD OF RHODE ISLAND	PO BOX 69427	HARRISBURG	PA	171069427	8008312400	DENTAL ONLY
F49	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	
F49DN	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	DENTAL ONLY
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	8006776669	
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	8773522583	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0A	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF OF GA.
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	2083447411	
X2VDN	BLUE CROSS OF IDAHO HEALTH SERVICE	PO BOX 7408	BOISE	ID	83707	2083447411	DENTAL ONLY
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	8006348644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	8668260914	
X0M	BLUE CROSS OF MASSACHUSETTS, INC.	PO BOX 986020	BOSTON	MA	022986020	8002535210	
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK, INC.	PO BOX 15013	ALBANY	NY	12212	5184385500	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	PO BOX 890179	CAMP HILL	PA	170890179	8008298599	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	8003621279	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	8097599898	
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	8007221471	
X1YDN	BLUE SHIELD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	8887024171	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	95927	8882351765	
X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	5184534600	
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	8007872680	
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	6123337651	
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	8007737752	
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	8643701800	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	9133426555	
739	BOLLINGER, INC.	PO BOX 727	SHORT HILLS	NJ	07078	8662670092	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	CODE ASSIGNED BY SCHA
702DN	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	DENTAL ONLY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
F53	BOON GROUP	PO BOX 559017	AUSTIN	TX	78755	8664750056	ADDED BY SC REVENUE AND FISCAL AFFAIRS
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	6178287000	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	3347751284	
D58	BRAVO HEALTH MEDICARE ADVANTAGE	PO BOX 4433	BALTIMORE	MD	21223	8005561570	MEDICARE ADVANTAGE PLAN
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	8002378447	
E89	BROADREACH MEDICAL RESOURCES	1350 BROADWAY #410	NEW YORK	NY	10018	8887182375	
852	BUILDERS MUTUAL INSURANCE CO	PO BOX 150006	RALEIGH	NC	276240006	8008094861	
E30	BUSINESS ADMINISTRATORS AND CONSULTANTS, INC.	PO BOX 107	REYNOLDSBURG	OH	43068	8005212654	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	8669272200	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	8887302244	
658	CALHOUN COUNTY						
973	CAMBRIDGE INTEGRATED SERVICES GROUP, INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	8007669780	USE CARRIER 171 AON
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	8003879919	
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD., STE. 100	ATLANTA	GA	30348	8003332542	
X2K	CAPITAL BLUE CROSS	PO BOX 211457	EAGAN	MN	551213057	8009622242	
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	8009267526	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 188061	CHATTANOOGA	TN	37422	8886506566	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	2166966400	
128	CAPITOL LIFE INSURANCE COMPANY	PO BOX 1200	DENVER	CO	80201	8005252115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER
F18	CARE CONNECT	PO BOX 830259	BIRMINGHAM	AL	352830259	8557067545	
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	8666862506	MEDICARE ADVANTAGE PLAN
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	8003482922	
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	8004880134	
F56	CAREFIRST BLUECHOICE MARYLAND	PO BOX 14116	LEXINGTON	KY	40512	8008425975	ADDED BY SC REVENUE AND FISCAL AFFAIRS
151	CARELINK	PO BOX 7373	LONDON	KY	40742	8003482922	MEDICAID HMO

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	8003030187	
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	8008415550	USE CARRIER 471
903	CAREPLUS HEALTH PLAN	PO BOX 31286	TAMPA	FL	336313286	8008674445	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	8002840042	CODE IN OPEN STATUS BY SCHA
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	8656707790	MEDICARE ADVANTAGE PLAN
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	8008100906	DORMANT 8/06
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON-SALEM	NC	271571137	8004757900	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	8645736937	
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	8003153143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
445DN	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO.	PO BOX 6018	CLEVELAND	OH	441011018	800315314	DENTAL ONLY
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	8032566265	
E12	CAROLINA CRESCENT	1201 MAIN ST., STE. 970	COLUMBIA	SC	29201	8032516630	HEALTHY KIDS CONNECTION
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	8436613875	
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	8037507473	MEDICARE ADVANTAGE PLAN
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE.	CLEVELAND	OH	44114	8004213959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN)	PO BOX 968022	SCHAUMBERG	IL	60196	8009626294	
B59	CASTIARX	701 EMERSON RD., STE. 301	CREVE COEUR	MO	63141	8665163121	
CAS	CASUALTY CASE						
366	CATALYST RX	PO BOX 968022	SCHAUMBERG	IL	601968022	8009973784	
572	CATAMARAN	PO BOX 29044	HOT SPRINGS	AR	71093	8778398119	FORMERLY HEALTH TRANS
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	3094942363	
C04	CBA BLUE	PO BOX 9350	SOUTH BURLINGTON	VT	05407	8882229206	DENTAL ONLY

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1339	MINNEAPOLIS	MN	55440	8008243882	
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	8004777870	
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	8007662525	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	6144645870	
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	8007725924	CODE ASSIGNED BY SCHA
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	8003213997	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	4023971111	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	7135290045	
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	8884441995	NEIC 30018
813	CENTURY PLANNER	9201 WATSON RD., STE. 350	ST. LOUIS	MO	631261509	8007762453	
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	3033317599	
659	CHARLESTON COUNTY						
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	MEDICAID HMO
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	8888031780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
660	CHEROKEE COUNTY						
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	8002010450	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	8887563534	
661	CHESTER COUNTY						
662	CHESTERFIELD COUNTY						
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	8003210935	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPARTANBURG	SC	293054217	8645962227	CODE ASSIGNED BY SCHA
E51	CHOICE BENEFITS	3801 OLD GREENWOOD RD.	FT. SMITH	AR	75278	8004516907	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	8007731445	
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	8008070400	
134	CIGNA	PO BOX 182223	CHATTANOOGA	TN	374227223	8008824462	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
511	CIGNA BEHAVIORAL HEALTH	PO BOX 188022	CHATTANOOGA	TN	37422	8003364091	
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	8002446224	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	USE CARRIER CODE 718
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211		CODE ASSIGNED BY SCHA
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	8007203150	BOUGHT BY CIGNA HEALTHCARE CC 134
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	8004412668	
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	8005779410	MEDICARE ADVANTAGE PLAN
718	CIGNA PHARMACY SERVICES	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	6152445600	MEDICARE INTERMEDIARY
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	8008471148	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD. #332	LAKE HIAWATHA	NJ	080341997	8008471148	CODE IN OPEN STATUS BY SCHA
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	8643340090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
F40	CITIZEN'S RX	1144 LAKE ST.	OAK PARK	IL	60301	8775327912	RX ONLY
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	5022442420	
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	8667691157	MEDICARE ADVANTAGE PLAN
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	8063784235	CODE IN OPEN STATUS BY SCHA
114	CLAIMEDIX, INC.	PO BOX 140067	KANSAS CITY	MO	64114	8009224262	CODE ASSIGNED BY SCHA
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREEN BAY	WI	54307	8004727130	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	8008379600	RX CARRIER ONLY
A73	CLAIMS TECHNOLOGY, INC.	100 COURT AVE., STE. 306	DES MOINES	IA	50309	8002458813	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
663	CLARENDON COUNTY	-	-	-	-		
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	8005083772	
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	8004267453	
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	8435382876	CODE IN OPEN STATUS BY SCHA
664	COLLETON COUNTY						
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	8037987000	
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	8005234000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	5123453200	
133	COMBINED INSURANCE COMPANY OF AMERICA	PO BOX 6700	SCRANTON	PA	18505	8002254500	
609	COMM FOR BLIND						
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	8002239941	
457	COMMERICAL TRAVELERS	70 GENESSE ST.	UTICA	NY	13502	8007563702	CODE ASSIGNED BY SCHA
986	COMMONWEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	8005261677	
F55	COMMONWEALTH CARE ALLIANCE	PO BOX 2280	PORTSMOUTH	NH	14315	8666102273	ADDED BY SC REVENUE AND FISCAL AFFAIRS
B36	COMMONWEALTH INDEMNITY PLAN	PO BOX 9016	ANDOVER	MA	01810	8004429033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	8006428065	MEDICARE ADVANTAGE PLAN
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	8889628437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	8888008717	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	5132821016	CODE IN OPEN STATUS BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	8008681032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	8037880500	
B65	COMPASS ROSE HEALTH PLAN	PO BOX 141501	NASHVILLE	TN	37214	8775311159	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	8005940977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C56	COMPDENT	1930 BISHOP LANE STE. 132	LOUISVILLE	KY	40218	8006331262	
A39	COMPLETE BENEFITS SOLUTIONS	6071 CARMEL RD., STE. 305	CHARLOTTE	NC	28226	8662702316	
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	8008283605	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	8775955282	
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	8002517722	
882	CONNECTICARE	PO BOX 4000	FARMINGTON	CT	06034	8772248230	CODE ASSIGNED BY SCHA
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	8005412254	
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	8009470319	USE CODE 282 WASHINGTON NATIONAL
C16	CONSOLIDATED BENEFITS, INC.	PO BOX 23686	COLUMBIA	SC	29224	8037365088	
F22	CONSOLIDATED HEALTH PLANS	2077 ROOSEVELT AVE.	SPRINGFIELD	MA	01104	8006337867	DENTAL
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	8009195514	CODE ASSIGNED BY SCHA
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	8007896364	
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD., STE. 700	ATLANTA	GA	303501853	8003654944	
154	CONSUMER DRN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	8884114208	CODE ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	8645739541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
592	CONTEC	525 LOCUS GROVE RD.	SPARTANBURG	SC	29303	8645038333	CODE ASSIGNED BY SCHA
F28	CONTINENTAL BENEFITS	PO BOX 3610	BRANDON	FL	335093610	8553030837	
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	4023973200	
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	8002644000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	8037824947	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	8002477724	
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	8002883343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	8005932080	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	4024839250	
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	8668734516	CODE IN OPEN STATUS BY SCHA
211	COORDINATED BENEFIT PLANS, INC.	PO BOX 853925	RICHARDSON	TX	750853925	8007531000	
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	8887412673	
552	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
552DN	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	8886049397	CODE IN OPEN STATUS BY SCHA
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	8004446965	
857	CORPORATE BENEFIT SERVICES, INC.	PO BOX 211778	EAGAN	MN	55121	7043730447	
857DN	CORPORATE BENEFIT SERVICES, INC.	PO BOX 12954	CHARLOTTE	NC	28220	7043730447	
A98	MERITAIN HEALTH	PO BOX 853921	RICHARDSON	TX	75085	8007654224	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	8886049397	
780	CORPORATE SYSTEMS ADMINISTRATION, INC.	PO BOX 4985	JOHNSON CITY	TN	376024985	8002752847	
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	7702396230	
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	8008891947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	8008337423	
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	8667321017	
443	COVENTRY HEALTHCARE OF KANSAS	PO BOX 7109	LONDON	KY	39026	8667858077	CODE ASSIGNED BY SCHA
B22	COVENTRY HEALTHCARE OF VIRGINIA	PO BOX 7704	LONDON	KY	40742	8006274872	
246	COVENTRY HEALTH CARE RX	PO BOX 8400	LONDON	KY	40742	8009476824	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
879	COVENTRY OF THE CAROLINAS	PO BOX 7102	LONDON	KY	40742	8662083610	FORMALLY WELLPATH
245	COVENTRY OF THE CAROLINA'S	PO BOX 7102	LONDON	KY	40742	8009357284	
632	CRIME VICTIMS						
155	CROSSAMERICA HEALTH PLAN	PO BOX 5778	PARSIPPANY	NJ	07054	8663027332	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	8645856456	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	6082385851	
E93	CUSTOM DESIGN BENEFITS	5589 CHEVIOT RD.	CINCINNATI	OH	45247	8005982929	
194	DAKOTACARE	PO BOX 7406	SIOUX FALLS	SD	571177406	8003255598	CODE ASSIGNED BY SCHA
665	DARLINGTON COUNTY						
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	8002480457	
A65	DATARX	5920 ODELLE ST.	CUMMINGS	GA	30040	8778231273	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	8037320060	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	8003484512	
B70	DECARE DENTAL	PO BOX 1348	MINNEAPOLIS	MN	55440	8005876857	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	8663334648	BROUGHT OUT BY UNITED HEALTHCARE CARRIER 113
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	8005212651	
370	DELTAHEALTH SYSTEMS	PO BOX 9554	SALT LAKE	UT	84109	8774740605	WAS P5 HEALTH PLUS SOLUTIONS
370DN	DELTAHEALTH SYSTEMS	PO BOX 702500	WEST VALLEY	UT	84170	8774740605	
879DN	DENEX DENTAL	111 ROCKVILLE PIKE STE. 700	ROCKVILLE	MD	20850	8666904908	DENEX DENTAL IS A PLAN UNDER WELLPATH SELECT/COVENTRY
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	8004459090	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	8003679466	
F32	DENTAL SELECT	PO BOX 851917	RICHARDSON	TX	75085	8014953000	DENTAL
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	8003076553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR
F13	DENTEGRA	PO BOX 1850	ALPHARETTA	GA	300231850	8772804202	DENTAL

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
621	DEPT CORRECTIONS						
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	8007773622	
450	DESERET SECURE	PO BOX 45530	SALT LAKE CITY	UT	841450530	8772200110	MEDICARE ADVANTAGE PLAN
955	DESIGN SAVERS PLAN	2814 SPRING RD., STE. 122	ATLANTA	GA	30339	8006165709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
611	DHEC C. CHILDREN						
610	DHEC CANCER						
629	DHEC FAMILY PLANNING						
627	DHEC HEART						
628	DHEC HEMOPHILIA						
613	DHEC HIGH RISK MATERNITY						
612	DHEC LOW RISK MATERNITY						
625	DHEC MIGRANT HEALTH						
626	DHEC SICKLE CELL						
615	DHEC STERILIZATION						
630	DHEC TB						
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	8645852046	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	4236396145	
666	DILLON COUNTY						
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD.	DILLON	SC	29536	8437747353	
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR., STE. 420	ALPHARETTA	GA	30202	7706645594	
F37	DISTRICT COUNCIL #37	125 BARCLAY ST.	NEW YORK	NY	10007	2158151600	DENTAL ONLY
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	8883222524	
474	DIVERSIFIED PHARMACEUTICAL	PO BOX 169052	DULUTH	MN	55816	8002338065	USE CODE 333 EXPRESS SCRIPTS
667	DORCHESTER COUNTY						
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	8884568417	
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E	EAST ORANGE	NJ	07018	8005240227	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B63	EASTERN LIFE AND HEALTH INSURANCE	PO BOX 10188	LANCASTER	PA	17605	8002330307	
A14	EB RX	2045 MIDWAY DR.	TWINSBURG	OH	44087	8008007153	
668	EDGEFIELD COUNTY						
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	7173972751	
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	8887768851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	7189218818	MEDICARE ADVANTAGE
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	2125014444	
X0EDN	EMPIRE BCBS DENTAL	PO BOX 791	MINNEAPOLIS	MN	554400791	8007228879	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	8003429816	
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	8037888562	MEDICARE ADVANTAGE PLAN
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8642356474	
A90	EMPLOYEE BENEFIT CLAIMS, INC.	9501 WEST DEVON	ROSEMONT	IL	60018	3126963660	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	8005587798	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	8007773575	
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	EXETER	NH	03833	8002587298	
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	8035778051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
345	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
345DN	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE., STE. 235	KALAMAZOO	MI	49007	8003257477	
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	8005520455	
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	8177617611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
D79	EMPLOYEE HEALTH INSURANCE MANAGEMENT (EHIM)	26711 NORTHWESTERN HWY STE. 400	SOUTHFIELD	MI	48033	8003113446	
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT. WAYNE	IN	468012362	2606257500	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
550	EMPLOYEE SECURITY, INC.	7125 THOMAS EDISON DR., STE. 105	COLUMBIA	MD	21046	8006381134	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	8008729934	CARRIER WAS FIRST INTEGRATED HEALTH
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	8889628437	CARRIER WAS COASTAL STATE LIFE INS. CO.
C24	ENCOMPASS HEALTH MANAGEMENT SYSTEM	6000 WEST TOWN PARKWAY STE. 350	DES MOINES	IA	50266	8005113389	
824	ENVISION RX OPTIONS	2181 EAST AURORA RD., STE. 201	TWINSBURG	OH	44087	8003614542	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	8003525150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	8007492631	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
180	ESIS	PO BOX 31122	TAMPA	FL	33631	8008847975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
461	EVERCARE	PO BOX 31350	SALT LAKE CITY	UT	841310350	8888668298	MEDICARE ADVANTAGE PLAN
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY	FL	34656	8008814474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X2F	EXCELLUS BLUECROSS BLUESHIELD	PO BOX 21146	EAGAN	MN	551210146	8007344069	TO VERIFY DENTAL COVERAGE CALL 1-800-724-1675
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	8778839577	MEDICARE ADVANTAGE PLAN
333	EXPRESS SCRIPTS	PO BOX 14713	LEXINGTON	KY	40512	8004516245	
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	8642991720	CODE IN OPEN STATUS BY SCHA
669	FAIRFIELD COUNTY						
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	8008685200	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD., STE. 300	SAN ANTONIO	TX	782181610	8008999355	
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	8037883860	
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	8005220041	
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOX 31716	TAMPA	FL	336313716	8134968100	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	8008744723	
738	FHA-TPA DIVISION	PO BOX 327810	FT. LAUDERDALE	FL	333329711	8037988698	CODE IN OPEN STATUS BY SCHA
F25	FIDELIO DENTAL INSURANCE COMPANY	2826 MT. CARMEL AVE.	GLENSIDE	PA	19038	8002624949	DENTAL
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	8006488624	
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST.	MIDDLETOWN	NY	10940	8008267531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	8002223693	
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	8008482664	USE CODE 139
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	8002060827	
348	FIRST AGENCY, INC.	5071 WEST H AVE.	KALAMAZOO	MI	490098501	2693816630	THIS CODE ASSIGNED BY SCHA 8/28/07
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015		CODE ASSIGNED BY SCHA
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	8008113298	
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	8003035770	
B90	FIRST CHOICE VIP CARE	PO BOX 307	LINTHICUM	MD	210900307	8005750418	THIS IS A MEDICARE ADVANTAGE PLAN.
789	FIRST COMMUNITY HEALTH PLAN, INC.	PO BOX 382947	BIRMINGHAM	AL	35238	8007347826	CODE IN OPEN STATUS BY SCHA
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	8005381235	
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	8668478235	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	8005544954	
456	FIRST HEALTH (A COVENTRY HEALTH CARE CO)	PO BOX 21680	EAGAN	MN	551210680	8664775465	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	8005544954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	8666848090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
139	FISERV HEALTH	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	WAS WAUSAU INS. CO.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	8004468182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
670	FLORENCE COUNTY						
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	8002263155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	9043548335	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	8007414810	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	8009909058	
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD.	FRANKLIN	TN	37067	6157784000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	8774925870	
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG. 3 #400	AUSTIN	TX	78730	8883687910	
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	8004415501	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	8009919155	
B79	FOX-EVERETT, INC.	PO BOX 6012	RIDGELAND	MI	39158	8774766327	
765	FREEDOM HEALTH	PO BOX 151348	TAMPA	FL	33684	8004012740	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 1468	ARLINGTON	TX	76004	8669734647	
F50	FRINGE BENEFIT GROUP	PO BOX 21854	EAGAN	MN	55121	8772201862	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS OFFICE
A97	FRINGE BENEFIT GROUP	PO BOX 21854	EAGAN	MN	55121	8554951190	
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	8886787012	
842	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
842DN	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	8006855209	MEDICARE ADVANTAGE PLAN
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	8882558961	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	8002530856	
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	8004989731	MEDICARE ADVANTAGE PLAN
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	8002428923	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ATLANTA	GA	30366	4044579555	CODE ASSIGNED BY SCHA
728	GENERAL PRESCRIPTION PROGRAMS, INC.	305 MADISON AVE. STE. 1166B	NEW YORK	NY	10165	8003412234	
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	8008764582	WAS GE FINANCIAL SERVICES
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	8778259337	CODE IN OPEN STATUS BY SCHA
C34	GEOBLUE	933 FIRST AVE.	KING OF PRUSSIA	PA	19406	8552823517	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
671	GEORGETOWN COUNTY						
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	8005666710	
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	8006266402	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	8649875200	
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	8002533074	
905	GERBER LIFE MEDICARE SUPPLEMENT	PO BOX 2271	OMAHA	NE	68103	8776565425	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	8004974474	
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	8002342643	
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	8139366242	
A44	GLOBAL MEDICAL MANAGEMENT, INC.	7901 SW 36TH ST., STE. 100	DAVIE	FL	33328	9543706404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	9725406542	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	9419366242	
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	3178942000	
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	2167966531	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	8162575500	
302DN	GOVERNMENT EMPLOYEE HOSP. ASSOC. (GEHA)	PO BOX 2336	INDEPENDENCE	MO	64051		DENTAL COVERAGE
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	8008802745	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR.	KENNETT	MO	63857	8006638081	
308	GREAT WEST LIFE	PO BOX 188061	CHATTANOOGA	TN	374228061	8006638081	GREAT WEST/CIGNA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
308DN	GREAT WEST LIFE	PO BOX 21542	EAGAN	MN	55121	8774342336	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	7042258887	
672	GREENVILLE COUNTY						
673	GREENWOOD COUNTY						
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	8662063224	
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	8475191880	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	8006386085	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	2013433003	
906	GROUP HEALTH ADMINISTRATOR, INC.	PO BOX 6244	CHARLOTTE	NC	282071018	8002225790	
508	GROUP HEALTH, INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	2125014444	
889	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
889DN	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	8003597408	
A83	GROUP RESOURCES, INC.	PO BOX 100043	DULUTH	GA	300969343	7706238383	
D46	GROUPHEALTH OPTIONS, INC.	PO BOX 34585	SEATTLE	WA	98124	8887674670	MEDICARE ADVANTAGE PLAN
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	8004624660	
236	GUARANTEE TRUST LIFE INSURANCE	PO BOX 1144	GLENVIEW	IL	60025	8476990600	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	8668501256	MEDICARE ADVANTAGE PLAN
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	8668501253	MEDICARE ADVANTAGE PLAN
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	8006854542	CODE ASSIGNED BY SCHA
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 981572	EL PASO	TX	799981572	8005417846	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	P O BOX 981572	EL PASO	TX	799981572	6108076000	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	8005956949	
674	HAMPTON COUNTY						
A96	HAMRICKS, INC.	742 PEACHOID RD.	GAFFNEY	SC	29340	8644877505	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	8777370769	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	7045366230	
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	8004213550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A84	HCC LIFE INSURANCE COMPANY	PO BOX 2005	FARMINGTON HILLS	MI	48333	8664004102	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	8008655440	
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	8003227451	
823	HEALTH ALLIANCE PLAN	PO BOX 02459	DETROIT	MI	48202	8004224641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	8007888445	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	4047555665	
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013		CODE IN OPEN STATUS BY SCHA
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	8663736366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209		CODE ASSIGNED BY SCHA
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	8005544022	CODE ASSIGNED BY SCHA
562	HEALTH CLAIMS SERVICES,INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	8002223560	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	8882295020	WAS LIFECARE CENTERS OF AMERICA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	8008930777	
960	HEALTH EOS	PO BOX 6090	DER PERE	WI	541156090	8004355694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
286	HEALTH EXCHANGE (TPA FOR CERNER HEALTH)	PO BOX 165750	KANSAS CITY	MO	64116	8002314015	CODE IN OPEN STATUS BY SCHA
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	8642893000	
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	8007167737	CODE IN OPEN STATUS BY SCHA
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	9004387886	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	8887477823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	8003371421	CODE ASSIGNED BY SCHA
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE, STE. 1500	SPRINGFIELD	MA	011441500	8003102835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	8889222313	
B01DN	HEALTH PARTNERS DENTAL	PO BOX 1172	MINNEAPOLIS	MN	55440	8889222313	
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	8156335800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	8007771840	MEDICARE ADVANTAGE PLAN
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	8002936260	
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630	8002377767	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	8008610056	CODE ASSIGNED BY SCHA
332	HEALTH PLANS, INC.	PO BOX 5199	WESTBOROUGH	MA	01581	8005327575	
324	HEALTH REIMBURSEMENT MANAGEMENT PARTNERSHIP	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
F46	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	
F46DN	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	DENTAL ONLY
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	5104497070	
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	9724926474	
F41	HEALTHCARE HIGHWAYS RX	5904 STONE CREEK DR.	THE COLONY	TX	75056	8446367506	RX ONLY
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	8005544022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	8004892974	CODE ASSIGNED BY SCHA
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	8004427247	
E61	HEALTHEZ	PO BOX 398220	MINNEAPOLIS	MN	55439	8552809638	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	8004778957	CODE ASSIGNED BY SCHA TPA
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	8882601010	MEDICARE ADVANTAGE PLAN
639	HEALTHFIRST HMO	255 ENTERPRISE BLVD., STE. 20	GREENVILLE	SC	29615	8644551100	MEDICAID HMO

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
387	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	HEALTHGRAM FORMERLY PRIMARY PHYSICIAN CARE
387DN	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	DENTAL - HEALTHGRAM FORMERLY PRIMARY PHYSICIANS CARE
577	HEALTHMARKETS CARE ASSURED	PO BOX 69349	HARRISBURG	PA	17110	8772195460	CODE ASSIGNED BY SCHA
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	8006417761	
753	HEALTHNET	PO BOX 2226	AUGUSTA	GA	309032226	9009778221	
F20	HEALTHPLEX	PO BOX 9255	UNIONDALE	NY	11553	8004680600	DENTAL
767	HEALTHSCOPE BENEFITS	PO BOX 619055	DALLAS	TX	752619055	8006006212	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	8009676831	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	8009676831	
553	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	8883736102	
305	HEALTHSMART	PO BOX 91608	LUBBOCK	TX	79490	8668695597	
C32DN	HEALTHSMART	PO BOX 91608	LUBBOCK	TX	79490	8004354351	FORMALLY WELLS FARGO
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	8064732500	
876	HEALTHSOURCE OF NC, INC.	PO BOX 28087	RALEIGH	NC	27611	8008499000	USE CODE 134 CIGNA HEALTHCARE
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	8778939294	
D81	HEARTLAND NATIONAL LIFE INSURANCE CO.	PO BOX 2878	SALT LAKE CITY	UT	84110	8008723860	REQUESTED BY THE SCHA
242	HELLER ASSOCIATES	8228 MAYFIELD RD., STE. 5B	CHESTERLANDE	OH	44026	4405272955	CODE IN OPEN STATUS BY SCHA
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	8002822460	
732	HERTZ CLAIM MANAGEMENT	PO BOX 726	PARK RIDGE	NJ	07656	2013072177	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	8642405840	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 890062	CAMPHILL	PA	170890062	4125447000	
D45	HIGHMARK SECURITY BLUE	120 5TH AVE.	PITTSBURGH	PA	15222309	8005473627	MEDICARE ADVANTAGE PLAN
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	8883502002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	8007439264	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	8004478255	MEDICARE ADVANTAGE PLAN
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	8002792624	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	8004043344	
A68	HOLLINGSWORTH SACO LOWELL CORP.	PO DRAWER 2327	GREENVILLE	SC	29602	8648593211	DORMANT 8/06
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	8004934240	
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	8007737725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	2177892500	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	8007923666	
675	HORRY COUNTY						
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	8009372036	
878	HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	8002530966	
836	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
836DN	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
C59	HUMANA CHOICE (PPO)	PO BOX 14605	LEXINGTON	KY	405784602	8004574708	MEDICARE ADVANTAGE PLAN
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	8775115000	MEDICARE ADVANTAGE PLAN
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	8004574708	MEDICARE ADVANTAGE PLAN
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	8004574708	
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	8005912650	CODE ASSIGNED BY SCHA
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	8006589777	
250	IDEAL SCRIPTS	50 WHITE CAP DR.	NORTH KINGSTOWN	RI	02886	8007176614	
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	8882738020	
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	8009442833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	8884463327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A08	INDEPENDENCE AMERICAN INS. CO. (IHC HEALTH SOLUTION)	PO BOX 21456	EAGON	MN	55121	8664290608	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1G	INDEPENDENCE BLUE CROSS	PO BOX 211184	EAGAN	MN	551212594	8002752583	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8002471466	
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8666178585	MEDICARE ADVANTAGE PLAN
975	INFORMED RX	PO BOX 968022	SCHAUMBURG	IL	601968022	8006453332	WAS NATIONAL MEDICAL HEALTH CARD
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	8775592955	
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
178	INSURANCE & BENEFIT ADVOCATE, INC.	5838 W BRICK RD STE. 106	SOUTH BEND	IN	46628	8662006700	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	8008433106	
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	8009896739	
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	2126184000	
756	INSURANCE MANAGEMENT ADMINISTRATORS (IMA)	PO BOX 71120	BOSSIER CITY	LA	711719944	8007429944	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	8008783157	
F51	INSURANCE TPA	PO BOX 15953	LUBBOCK	TX	79490	8558489591	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS
C41	INTERNATIONAL BENEFITS ADMINISTRATORS	PO BOX 9306	GARDEN CITY	NY	11530	8004227617	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
B80	INTEGRATED BEHAVIORAL HEALTH/IBH	PO BOX 30018	LAGUNA NIGUEL	CA	92607	8003951616	
735	INTEGRITAS BENEFIT GROUP	PO BOX 1447	CORDOVA	TN	38088	9016858980	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	7704281604	
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	5024261843	CODE ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR., STE. 400	DALLAS	TX	75231	8009593953	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	3037705710	
809	INTER VALLEY HEALTH PLAN	300 SOUTH PARK, PO BOX 6002	POMONA	CA	917696002	8002518191	CODE ASSIGNED BY SCHA
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 1349	WAKE FOREST	NC	27588	8004268739	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR., STE. 150	MALVERN	PA	19355	8005379389	
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT. #205	HILLSBORO	OR	97124	5036402000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE. NORTH WEST	WASHINGTON	DC	20006	8002751171	
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE.	PHOENIX	AZ	85040	6022340497	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST.	FOOTHILL RANCH	CA	92610	8779167920	ASSIGNED BY SCHA
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	8664337462	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	8006284664	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	8042191585	CODE ASSIGNED BY SCHA
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	9085486662	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	8665114757	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC.`	3 TOILSOME LANE	EAST HAMPTON	NY	11937	8009262306	CODE ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	9728816000	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	8882954864	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	8003313287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	4402504300	
676	JASPER COUNTY						
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	3366913000	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	8007933773	NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD.	JACKSONVILLE	FL	32256	8008920059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	8002331449	
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY ST.	BOSTON	MA	02116	8003777311	
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	8002612393	
417	JULY PRODUCTS	5 GATEWAY CENTER STE. 60	PITTSBURG	PA	15222	8669008322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	8003310420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	8003903510	CODE ASSIGNED BY SCHA
528	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	8006111811	MEDICARE ADVANTAGE PLAN
C78	KAISER PERMANENTE	PO BOX 370010	DENVER	CO	80237	4042612590	
F58	KAISER PERMANENTE MID ATLANTIC STATES	PO BOX 371860	DENVER	CO	802379998	8008104766	ADDED BY REVENUE AND FISCAL AFFAIRS
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	8006348816	CODE ASSIGNED BY SCHA
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
868	KANSAS CITY LIFE	PO BOX 9040	AUSTIN	TX	78766	8008745254	
E80	KANSAS INDEPENDENT PHARMACY (KPSC)	4125 SOUTH WEST GAGE CENTER DR., STE. 203	TOPEKA	KS	66604	8002793022	
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	8006533626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
677	KERSHAW COUNTY						
760	KEY BENEFIT ADMINISTRATORS	PO BOX 3252	MILWAUKEE	WI	53201	8003314757	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 3252	MILWAUKEE	WI	53201	8668676883	
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	8002273116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	8002273116	MEDICARE ADVANTAGE PLAN
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	8002472192	USE CODE 759 MEDIPLUS PER SCHA
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	3308678443	
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	9204574441	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	4044771888	
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	6019493100	
678	LANCASTER COUNTY						
679	LAURENS COUNTY						
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	8008158240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
680	LEE COUNTY						
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	8773112150	
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	3055595366	MEDICARE ADVANTAGE PLAN
681	LEXINGTON COUNTY						
B62	LIBERTY DENTAL	PO BOX 26110	SANTA ANNA	CA	92799	8889020349	
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	2053252722	
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	6157491000	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	8002262371	
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	8042816000	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	5013760426	AKA AEGON
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	8006616385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	8002291024	
F19	LIFEMAP	PO BOX 783	MILWAUKEE	WI	53201	8002841129	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D87	LIFESTYLE HEALTHCARE	345 N. RIVERVIEW STE. 600	WICHITA	KS	67203	8668276607	FORMERLY MEDOVA HEALTHCARE
F45	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	
F45DN	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	DENTAL ONLY
138	LIFEWELL HEALTH PLANS	PO BOX 16203	LUBBOCK	TX	79490	8775433935	SUBSIDIARY OF HEALTHSCOPE
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	8004232765	
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	8885868810	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	8004232765	
796	LINECO	821 PARKVIEW BLVD.	LOMBARD	IL	601483230	8003237268	CODE ASSIGNED BY SCHA
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	8007820392	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	8006336752	
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD.	MINNEAPOLIS	MN	55305		CODE ASSIGNED BY SCHA
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	8774957223	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	2156578920	CODE IN OPEN STATUS BY SCHA
396	MACY'S HR SERVICES	PO BOX 850958	RICHARDSON	TX	75085	8003372363	CODE ASSIGNED BY SCHA
C11	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281803	
C11DN	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281813	
B16	MAGELLAN RX	11013 W BROAD ST., STE. 500	GLEN ALLEN	VA	23060	8006594112	
A32	MAGELLAN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	8003592422	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	8666246259	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	8002807093	
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	8004107778	
E23	MAINE SENSE	PO BOX 1959	GRAY	ME	04039	8002908559	
159	MAKSIN MANAGEMENT CORP	CN98000	PENNSAUKEN	NJ	08110	8002570625	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDERICK	MD	21705	8002576458	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	8008352094	
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	7043555200	
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	8006729540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST. LOUIS	MO	631016922	8007596959	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	8006699030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
682	MARION COUNTY						
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	8002792290	
683	MARLBORO COUNTY						
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	8009348203	
709DN	MARSH ADVANTAGEAMERICA	501 NORTH BROADWAY, STE. 500	ST. LOUIS	MO	63102	8008687526	FORMERLY BENEFIT PLAN SERVICES
405	MARSH(INSURANCE TRUST PLAN-DELTA RETIREES)	PO BOX 10432	DES MOINES	IA	503060432	8773257265	CODE ASSIGNED BY SCHA
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR., STE. 130	SPARTANBURG	SC	29307	8645733535	
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	8009538854	CODE IN OPEN STATUS BY SCHA
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	7068635955	
B32	MAXCARE	PO BOX 16430	OKLAHOMA CITY	OK	73113	8002597765	
E99	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	
E99RX	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	RX ONLY
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD.	PITTSBURGH	PA	15220	4129220780	WAS DIVERSIFIED GROUP ADMINISTRATORS
684	MCCORMICK COUNTY						
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE. 310	PONTE VEDRA BEACH	FL	32082	8008416288	CODE ASSIGNED BY SCHA
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	2192370560	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON-SALEM	NC	271145307	8007951023	
206DN	MED COST BENEFITS SERVICES	PO BOX 25987	WINSTON-SALEM	NC	27114	8007951023	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
223	MED COST PREFERRED	PO BOX 25437	WINSTON-SALEM	NC	27114	8008247406	CODE ASSIGNED BY SCHA
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	8006868425	
798	MEDCARE INTERNATIONAL	12480 WEST ATLANTIC BLVD., STE. 2	CORAL SPRINGS	FL	33071	9543455650	
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	8002217006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
C46	MEDCO HEALTH SOLUTIONS	PO BOX 2902	CLINTON	IA	527332902	8002727243	USE CARRIER 333 EXPRESS SCRIPTS
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	8009523455	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	8009523455	
619	MEDICAID, SC						
616	MEDICAID-OUT-OF-STATE						
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	PO BOX 950	FORREST HILL	MA	60631	8885323467	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	6082731776	
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 25307	WINSTON-SALEM	NC	271145307	8003340609	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST., STE. 2A	RAVENSWOOD	WV	26164	8882250522	
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	8002582873	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	8003621279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X0R	MEDICAL MUTUAL OF OHIO	PO BOX 6018	CLEVELAND	OH	44101	2166877000	
X0RDN	MEDICAL MUTUAL OF OHIO	PO BOX 981800	EL PASO	TX	79998	2166877000	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	6159633826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST.	MIDDLETON	NY	10940	3173298222	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST.	INDIANAPOLIS	IN	462781758	3173298222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	5095364900	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D99	MEDICARE ADVANTAGE						MEDICARE ADVANTAGE PLAN GENERIC CODE
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	8778423210	MEDICARE ADVANTAGE PLAN
618	MEDICARE PART A						
620	MEDICARE PART B ONLY						
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD.	SOUTHFIELD	MI	48034	8002495103	MEDICARE ADVANTAGE PLAN
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	8772887600	
C99	MEDICO INSURANCE COMPANY	PO BOX 21660	EAGAN	MN	55121	8002286080	CARRIER WAS PREVIOUSLY C35
995	MEDIMPACT	10680 TREENA ST., STOP 5	SAN DIEGO	CA	92131	8007882949	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	9736963111	
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	8002472192	AKA TROA
E96	MEDPARTNERS ADMINISTRATIVE	6920 POINT INVERNESS WAY	FORT WAYNE	IN	46804	8883129744	
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD.	LAKELAND	FL	33805	8002263155	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	8003479355	
C96	MEDTRACK SERVICES	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
E41	MEDTRAK	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 981606	EL PASO	TX	79998	8005272845	
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	8888685854	
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	8008687526	
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	8006472240	
F14	MERIDIANRX	PO BOX 9306	GARDEN CITY	NY	48226	8553234580	RX
377	MERITAIN HEALTH	PO BOX 27267	MINNEAPOLIS	MN	554270267	8009252272	WAS NORTH AMERICAN ADMINISTRATORS, INC.
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	8006064841	
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	8006386626	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	8886425040	
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	8004584642	CODE ASSIGNED BY SCHA
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	8007527242	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	8007331110	
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	8009376432	
C95	MIDWEST SECURITY	2700 MIDWEST DR.	ONALASKA	WI	54650	8002368672	
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST.	DULUTH	MN	55802	8888128800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	8007771647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	8006356671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONG BEACH	CA	90801	8006424148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
774	MOLINA MEDICARE OPTIONS PLUS	PO BOX 22811	LONG BEACH	CA	90801	8006651328	MEDICARE ADVANTAGE PLAN
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	8006289000	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	8007529797	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	3175549000	
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	8002403870	MEDICARE ADVANTAGE PLAN
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	2084527979	CODE IN OPEN STATUS BY SCHA
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	8669527979	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	3044247700	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	2488539010	
432	M-PLAN CARDINAL HEALTH	PO BOX 357	LINTHICUM	MD	210900357	8006752605	CODE ASSIGNED BY SCHA
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	8888421530	CODE ASSIGNED BY SCHA
564	MULTINATIONAL UNDERWRITERS	PO BOX 863	INDIANAPOLIS	IN	46206	8006052282	CODE ASSIGNED BY SCHA
954	MULTIPLAN	115 5TH AVE.	NEW YORK	NY	100031004	8005463887	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
593	MUTUAL ASSURANCE ADMINISTRATORS, INC.	PO BOX 42096	OKLAHOMA CITY	OK	73123	8006489652	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	8004484689	CODE ASSIGNED BY SCHA
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	8002289090	DO NOT USE FOR MED ADV. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	4023427600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		MEDICARE INTERMEDIARY PART B
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	8002286080	SEE CODE C99
937	MVP HEALTH CARE	PO BOX 2207	SCHENECTADY	NY	12301	8002295851	NAME CHANGE ONLY 4/09. WAS PREFERRED CARE
937DN	MVP HEALTH CARE	PO BOX 763	SCHENECTADY	NY	12301	8004805640	
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	7037294677	
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	3015771700	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	2154430404	
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	8662199292	CODE IN OPEN STATUS BY SCHA
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	7043643865	CODE ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	7043643865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	7043643865	
444	NATIONAL DISASTER MEDICAL SYSTEM						
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	8005234702	
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	8008225899	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST., STE. 300	FT WORTH	TX	76102	8007251407	
B53	NATIONAL FOUNDATION LIFE INSURANCE COMPANY	110 WEST 7TH ST., STE. 300	FORT WORTH	TX	76102	8002219039	
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN (NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	6158902020	

APPENDIX 2 CARRIER CODES

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	8002371900	
828	NATIONAL PHARMACEUTICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	8005465677	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	8005226727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	8006388432	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST. LOUIS	MO	63141	3148780101	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	8886716771	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	8282529776	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	8002325818	INACTIVE 8/02
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	8008107856	
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	6142497111	
A52	NATIONWIDE SPECIALTY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	8005174791	
518	NAT'L ASBESTOS WORKERS MED FUND	PO BOX 188004	CHATTANOOGA	TN	37422	8003863632	
B67	NAVITUS HEALTH SOLUTIONS LLC	PO BOX 999	APPLETON	WI	549120999	8662682501	
800	NEBCO (TENNECO)	PO BOX 97	SCRANTON	PA	185040097	8007177562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE., PO BOX 3070	KNOXVILLE	TN	37927		
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	9207201300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	8004087681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	8006541731	
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD.	NORTH OLMSTED	OH	440705300	8002558063	
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	2813687200	
520	NEW JERSEY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	8006243096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	8005706745	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	8004761555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	8003884580	
D39	NEW YORK WELFARE FUND	101-49 WOODHAVEN BLVD.	OZONE PARK	NY	11416	7188455800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
685	NEWBERRY COUNTY						
B54	NGS AMERICAN, INC.	PO BOX 2310	MT. CLEMENS	MI	48046	8107797676	
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	8003741835	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	2123374900	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	6152563561	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	8003214085	
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	6086621232	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	9196829201	
594	NORWEST FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	5152432131	CODE ASSIGNED BY SCHA
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD.	GRAND ISLAND	NY	140720308	8003333195	
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	8282819000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	9198318189	
686	OCONEE COUNTY						
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	8773370650	
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	8002728451	
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	8167534900	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	8002725466	
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	3607349888	
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	8003149010	CODE ASSIGNED BY SCHA
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	8008246796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	8003423289	CODE ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	8002291199	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE. 1	NEWTOWN	PA	18940	8004828770	
891	OPTIMUM CHOICE OF THE CAROLINAS, INC.	4 TAFT CT.	ROCKVILLE	MD	20850	8003438205	
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	8642134992	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71093	8007887871	FORMERLY PRESCRIPTION SOLUTIONS
687	ORANGEBURG COUNTY						
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC			
624	OTHER SPONSOR						
696	OUT-OF-STATE GA						
697	OUT-OF-STATE NC						
698	OUT-OF-STATE OTHER						
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	8774693073	
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	8002341228	MEDICARE ADVANTAGE PLAN
394	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE CITY	UT	84109	8774740605	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	8176566040	USE CODE 477 MEGA LIFE
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	8007766070	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	8007332285	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	8004512513	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	8006246052	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	8663169776	CODE ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	8008513802	
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 981644	EL PASO	TX	799981644	8006949888	WAS US NOW INSURANCE GROUP
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 981644	EL PASO	TX	79998	8006949888	
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	7062776710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	8888912564	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON-SALEM	NC	271167368	8009425695	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	5087994441	
E24	PBM PLUS	300 TECHNECENTER DR., STE. C	MILFORD	OH	45150	8002632178	
A21	PC HEALTH PLAN ADMINISTRATION	PO BOX 1377	THOMASVILLE	GA	31799	8884261937	CODE ASSIGNED BY SCHA
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	8886226001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	8004441535	CODE ASSIGNED BY SCHA
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	8006357418	CODE ASSIGNED BY SCHA
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	8003620700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C49DN	PENN WESTERN BENEFITS, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008465370	
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	8006373493	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	8002757366	
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	8005237900	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	8885547629	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	8777776076	
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	8004311211	
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	8002376184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471
964	PHARMACEUTICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	8007770074	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	8887275560	SEE CARRIER 366 CATALYST RX
B47	PHARMACY DATA MANAGEMENT, INC.	1170 E WESTERN RESERVE RD.	POLAND	OH	44514	8007740890	
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD., STE. 101	RALEIGH	NC	27609	8003317108	SEE CARRIER 366 CATALYST RX
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD., BLDG. 400, UNIT 100	WOODSTOCK	GA	30188	8009333734	
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	8005527879	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	8005527879	CODE ASSIGNED BY SCHA
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	8003976241	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	8004512513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	8883239271	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	8008329186	
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	8008484747	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX 2018	OMAHA	NE	681032018	8002289100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	8005455015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
688	PICKENS COUNTY						
A22	PIEDMONT ADMINISTRATORS	PO BOX 25307	WINSTON-SALEM	NC	271145307	8008527040	
804	PIEDMONT COMMUNITY HEALTHCARE, INC.	PO BOX 14408	CINCINNATI	OH	452500408	8004007247	
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	8643759661	
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	8434235541	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	4046592100	CODE IN OPEN STATUS BY SCHA
395	PINNACLE CLAIMS MANAGEMENT, INC.	1630 E SHAW AVE., STE. 190	FRESNO	CA	93710	8006499121	CODE ASSIGNED BY SCHA
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	8004234586	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	8159875000	USE CODE 282 WASHINGTON NATIONAL
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	8002381344	
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW, STE. 500	WASHINGTON	DC	20005	2023936600	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	8005385512	
886	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
886DN	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	8887412673	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST.	PEEKSILL	NY	10566	9147377220	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	8002340225	
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
589	POLY AMERICA LP	2000 W MARSHALL DR.	GRAND PRAIRIE	TX	75051	8007855301	CODE IN OPEN STATUS BY SCHA
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	8002344393	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	7036835585	
A66	PRAIRIE STATES ENTERPRISES, INC.	PO BOX 23	SHEBOYGAN	WI	530820023	8008157020	
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	5163906000	
877	PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)	PO BOX 300	INDEPENDENCE	MO	640510300	8002207898	
A11	PREFERRED ADMINISTRATORS	15560 NORTH FLW BLVD.	SCOTTSDALE	AZ	85260	8772767198	
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	MEDICARE ADVANTAGE PLAN
347	PREFERRED CARE, INC. (PCI)	1300 VIRGINIA DR., STE. 315	FORT WASHINGTON	PA	19034	8002223085	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	8007228477	
909DN	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	2059691155	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	PO BOX 220397	CHARLOTTE	NC	28222	8666360239	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	5023397500	
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE.	ALTOONA	PA	166014899		CODE ASSIGNED BY SCHA
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	8009971750	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE.	PENSAUKEN	NJ	08109		CODE ASSIGNED BY SCHA
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	8032968999	CODE ASSIGNED BY SCHA
C65	PRESBYTERIAN HEALTHCARE SERVICES	PO BOX 27489	ALBUQUERQUE	NM	87125	8003562219	
397	PRIME THERAPEUTIC	PO BOX 25136	LEHIGH VALLEY	PA	18002	8886420447	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	8006177446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	4043811000	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	8004334893	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	8002474695	
817	PRIORITY HEALTH	PO BOX 232	GRAND RAPIDS	MI	49501	8004465674	
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 6090	DEPERE	WI	54115	6087793000	CODE ASSIGNED BY SCHA 6/18/07
F42	PROACT	1126 US HIGHWAY 11	GOUVERNEUR	NY	13642	8662869885	RX ONLY
B35	PROCARE RX PBM	1267 PROFESSIONAL PARKWAY	GAINESVILLE	GA	30507	8006993542	
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD., STE. 100	ORLANDO	FL	32814	8007410521	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	6306553755	
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD.	RALEIGH	NC	27607	8002891122	
E102	PROTECTIVE LIFE INSURANCE	PO BOX 12687	BIRMINGHAM	AL	35202	2052687055	CANCER POLICY ONLY
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	2627844600	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	8007535133	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	8006283912	CODE ASSIGNED BY SCHA
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	8005199175	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	8008415550	USE CODE 280 CAREMARK
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	8667747766	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	8003463778	THIS CARRIER BOUGHT OUT BY AETNA CC100
251	PYRAMID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	8006581413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	4076281776	MEDICARE ADVANTAGE PLAN
230	PYRAMID LIFE INSURANCE COMPANY	P O BOX 130	PENSACOLA	FL	32591	8004440321	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	8009926613	
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	8002357111	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	8005685628	DORMANT 8/06
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	8884371508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY MM PLAN IS X0K
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	5032255221	
795	REGIONAL MEDICAL ADMINISTRATORS, INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	3362267950	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82510	LINCOLN	NE	68501	8004977044	
197	RELIANCE STANDARD SPECIALTY PRODUCTS ADM	505 S LENOLA RD., STE. 231	MOORESTOWN	NJ	08057	8663750775	
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	8883589484	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	8006549106	
375	RESTAT	11900 WESTLAKE PARK DR.	MILWAUKEE	WI	53224	8009265858	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	8007363539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
689	RICHLAND COUNTY						
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD., STE. 100	ST. LOUIS	MO	63127	8003659036	CODE ASSIGNED BY SCHA
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	8007703740	
546	RISK MANAGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	3154489000	
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	8884792000	
278	ROCKY MOUNTAIN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	8008544558	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	8778158857	CODE ASSIGNED BY SCHA
406	RURAL CARRIER BENEFIT PLAN	PO BOX 7404	LONDON	KY	40742	8006388432	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A09	RX AMERICA	221 N CHARLES LINDBERG DR.	SALT LAKE CITY	UT	84116	8007708014	
B89	RXEDO	7800 DALLAS PARKWAY STE 460	PLANO	TX	75024	8888797336	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 6927	COLUMBIA	SC	29260	8037986207	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	8888008717	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	2068678000	
690	SALUDA COUNTY						
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD.	ROCKVILLE	MD	20852	8006386589	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD., STE. 201	WINSTON-SALEM	NC	27106	8006420483	
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	8003506714	
142	SC DEPT OF DISABILITIES AND SPECIAL NEEDS	PO BOX 4706	COLUMBIA	SC	29240	8038989795	CODE ASSIGNED BY SCHA
E91	SCOTT AND WHITE HEALTH PLAN	PO BOX 21800	EAGAN	MN	55121	8003217947	
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	8007774013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
846	SCRIPT CARE, INC.	6380 FOLSOM DR.	BEAUMONT	TX	77706	8008809988	
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	8005822498	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	8002524674	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	8665798811	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	8665798774	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	7148253828	MEDICARE ADVANTAGE PLAN
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	8882024340	MEDICARE ADVANTAGE PLAN
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	8002349009	NAIC 93742
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 82520	LINCOLN	NE	68501	8003009566	
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	8884458916	MEDICARE ADVANTAGE PLAN
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 3245	MILWAUKEE	WI	53201	8004973699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
E81	SELECT ADMINISTRATIVE SERVICES (SAS)	PO BOX 3209	GULFPORT	MS	39503	8008476621	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	8005385038	
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	8882762020	HEALTHY KIDS CONNECTION
883	SELECT HEALTH OF SOUTH CAROLINA, INC.	7410 NORTHSIDE DR., STE. 208	CHARLESTON	SC	29420	8435691759	CODE IN OPEN STATUS BY SCHA
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	8882762020	MEDICAID HMO
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	8003421895	
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	7275320400	
229	SELF INSURED PLANS LLC	1016 COLLIER CENTER WAY STE. 200	LOS ANGELES	CA	90080	8004212342	CODE ASSIGNED BY SCHA
378	SELF INSURERS SERVICE, INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282		
744	SENIOR DIMENSIONS	PO BOX 15645	LAS VAGAS	NV	891145645	8009257455	
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	8004267234	
A23	SERV U PRESCRIPTION	PO BOX 26096-0096	MILWAUKEE	WI	53226	8007593203	
D10	SEVEN CORNERS, INC.	PO BOX 3430	CARMEL	IN	46082	8666994186	
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	8003211855	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	8002482141	CODE ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	8008485433	
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST. PAUL	MN	55116	8883308408	
631	SHRINERS						
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	8002524624	
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	8882742207	MEDICARE ADVANTAGE PLAN
E97	SIGNATURE CARE	PO BOX 5548	FORT WAYNE	IN	46895	8006664449	
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	8008732022	
E82	SIMPLE BENEFIT PLANS	2810 PREMIER PARKWAY STE. 400	DULUTH	GA	30097	8002704158	
568	SIMPLIFI	PO BOX 922043	HOUSTON	TX	772922043	8884465710	FORMERLY CBCA ADMINISTRATORS

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B95	SINCLAIR HEALTH SERVICES	PO BOX 30827	SALT LAKE CITY	UT	84130	8888002230	
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	8007525863	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	8004574725	
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	8668659329	MEDICARE ADVANTAGE PLAN
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	8008672582	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	8002474526	
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	8008095916	
D82	SOLSTICE	PO BOX 14009	LEXINGTON	KY	40512	8777602247	
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE. 1400	ATLANTA	GA	30339	8004702004	
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	8005738597	
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
888	SOUTHEASTERN BENEFIT PLANS, INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	7045295400	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	8004268803	
897	SOUTHERN BENEFIT ADM.	PO BOX 188006	CHATTANOOGA	TN	37422	8006784656	
897DN	SOUTHERN BENEFITS ADMINISTRATORS DENTAL	5305 VIRGINIA BEACH BLVD.	NORFOLK	VA	23502	7574618091	
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	8008314914	
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	3237227171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	2133856161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	4238992593	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	8004579611	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON-SALEM	NC	27101	8003348159	
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	2818291033	
F11	SOUTHERN SCRIPTS	PO BOX 2482	NATCHIPOCHES	LA	71457	8007109341	RX
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	7709805100	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
691	SPARTANBURG COUNTY						
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721		CODE ASSIGNED BY SCHA
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	8007676811	CODE ASSIGNED BY SCHA
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	8006383120	
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE ASSIGNED BY SCHA
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	8778757700	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE.	MIAMI SHORES	FL	33138		CODE ASSIGNED BY SCHA
A46	STANDARD INSURANCE COMPANY	PO BOX 82622	LINCOLN	NE	68501	5033217000	
C42	STANDARD CORPORATION	1400 MAIN ST., STE. 1300	COLUMBIA	SC	29201	8037716785	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	8883501488	
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	8035483657	
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	8665131479	
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	8002881474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	8003085948	POLICIES BEGINNING WITH "R" NEED TO BE "E" INDICATORS AND GO TO PO BOX 188004, CHATTANOOGA, TN 37422. POLICIES WITH PH SSN STAYS AS "C".
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	8004564002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	8005221246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50 EMPLOYEES. SEE CC212 FOR GROUPS OVER 50 EMPLOYEES.
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8008682520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD.	WINTER HAVEN	FL	338880007	8633183000	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	8887806388	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	8003233359	CODE IN OPEN STATUS BY SCHA
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	8002728451	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST., STE. 1200	FORT WORTH	TX	761027012	8007828375	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	7135266000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	8776045240	
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	8006880010	
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	6152445600	MEDICARE ADVANTAGE PLAN
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010		MEDICARE ADVANTAGE PLAN
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	8003319955	
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	8005337896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
734	STRATEGIC OUTBURSTING, INC.	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	8887729682	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	8003282739	
A61	SUMMACARE HEALTH PLAN	PO BOX 3620	AKRON	OH	743893628	8009968701	
209	SUMMIT AMERICA INSURANCE SERVICES	PO BOX 25936	OVERLAND PARK	KS	662255936	8772466997	
692	SUMTER COUNTY						
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	8002253950	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	8772917920	
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	8774534201	
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	8883525246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	8005815300	CARRIER BOUGHT OUT BY PHARMACARE CC 740

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C50	TENNESSEE BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	8037721783	CODE ASSIGNED BY SCHA
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON-SALEM	NC	27116	8663074711	
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	8884113888	
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	8668269345	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	8002556065	
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	8002530856	CODE ASSIGNED BY SCHA
E43	THE HEALTH PLAN INSURANCE CO.	52160 NATIONAL RD. EAST	ST. CLAIRSVILLE	OH	43950	7406996273	
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	8005257268	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	8005479515	
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	8006315917	
315	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
315DN	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD.	APPLETON	WI	54919	8008474836	
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	7176324727	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	8005537654	USE 386 ASSURANT HEALTH
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	8662225137	MEDICARE ADVANTAGE PLAN
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	8664225009	MEDICARE ADVANTAGE PLAN
E46	TOLEDO FIREFIGHTERS HEALTH PLAN	PO BOX 5810	TROY	MI	480075810	4192555314	
755	TOTAL BENEFIT SERVICES, INC.	PO BOX 30180	NEW ORLEANS	LA	70190		
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	8007437141	MEDICARE ADVANTAGE PLAN
D55	TOTAL CAROLINA CARE, INC.	1441 MAIN ST.	COLUMBIA	SC	29210	8664336031	MEDICAID HMO
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	8003760110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	8003760110	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	8009695238	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	8007522211	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	8887770204	MEDICARE ADVANTAGE PLAN
A76	TOWER LIFE INS. CO.	310 S. MARY ST.	SAN ANTONIO	TX	78205	8006606077	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	8885022789	
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE. 201	LILBURN	GA	30047	7704517550	
788	TRANSAMERICA LIFE INSURANCE CO.	PO BOX 97	SCRANTON	PA	185040097	8008203372	CODE ASSIGNED BY SCHA
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	2137422111	
148	TRANSAMERICA PREMIER LIFE INSURANCE COMPANY	PO BOX 742502	CINCINNATI	OH	45274	8004445431	
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	7045443665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
F43	TRICARE EAST	PO BOX 7981	MADISON	WI	537077981	8004445445	
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	8667730404	
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	8009826257	CODE ASSIGNED BY SCHA 6/07/10
614	TRICARE WEST	PO BOX 202112	FLORENCE	SC	295022112	8004033950	INTERNET WWW.TRICARE-WEST.COM
E73	TRISTAR BENEFIT ADMINISTRATORS	PO BOX 65887	WEST DES MOINES	IA	50265	8004564584	
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	8002519665	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E42	TRUE RX	4 WILLIAMS BROTHERS DR.	WASHINGTON	IN	47501	8669214047	
E95	TRUESCRIPTS	PO BOX 921	WASHINGTON	IN	47501	8442571955	RX
F21	TRUSTEED PLAN SERVICE	PO BOX 2950	TACOMA	WA	98401	2535645611	
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	8476151500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50 EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	7045259666	
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	8004238080	
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	8004620224	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
729	U.A. LOCAL 446 PLUMBERS AND PIPEFITTERS	PO BOX 191030	SACRAMENTO	CA	958191030	9164570821	CODE IN OPEN STATUS BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	8003153440	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	8668587223	
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
356	UMR	PO BOX 2697	WICHITA	KS	67201	8008269781	USE CODE 139
812	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
139DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	84130	8008269781	WAS WAUSAU INS. CO.
143DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	8002368672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	8006781536	
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	8002888630	
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 659444	SAN ANTONIO	TX	75265	8772179677	
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	8772179677	WAS MASS MUTUAL
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR., STE. 3900	CHICAGO	IL	68606	3123247000	MEDICARE ADVANTAGE PLAN
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
E45	UNIFIED LIFE INSURANCE	PO BOX 25326	OVERLAND	KS	662255326	9136852233	
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	8007626004	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	2149547840	
693	UNION COUNTY						
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	8005236599	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	8004438087	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	8005470421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	8004446254	USE 386 ASSURANT HEALTH
E38	UNISON HEALTH PLAN	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	HEALTHY KIDS CONNECTION
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	MEDICAID HMO
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	8008721187	CODE ASSIGNED BY SCHA
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	9725295085	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	8008776003	CODE ASSIGNED BY SCHA
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	8005575745	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST.	FT. WORTH	TX	76107	8007320657	
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	8004344890	WAS POE & BROWN
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	8667448482	CODE ASSIGNED BY SCHA
124	UNITED COMMERICAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	8008480123	
737	UNITED CONCORDIA	PO BOX 69451	HARRISBURG	PA	17106	8003320366	
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	4046593300	
704	UNITED FOOD & COMMERICAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	8002417701	
421	UNITED FOOD & COMMERICAL WORKER HEALTH&WELFARE	911 RIDGEBROOK RD.	SPARKS	MD	211529451	8006382972	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
340	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVENUE OF THE CITIES, STE. 200	MOLINE	IL	61265	8002246602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	8005262414	USE CC113 UNITED HEALTHCARE
E90	UNITED HEALTH (MEDICARE SOLUTIONS)	PO BOX 30436	SALT LAKE CITY	UT	84130	8778423210	MEDICARE ADVANTAGE
584	UNITED HEALTH ONE	PO BOX 31374	SALT LAKE CITY	UT	841310374	8006578205	FORMALLY GOLDEN RULE
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	8778423210	
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	8005215505	
963	UNITED HEALTHCARE CLAIMS	PO BOX 29130	HOT SPRINGS	AR	71903	8882014111	
825	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 8207	KINGSTON	NY	12402	8006009007	MEDICARE ADVANTAGE PLAN
923	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 6170	COLUMBIA	SC	292606170	8008682528	MEDICAID MCO PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	124025230	8002246602	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	8607025000	MEDICARE ADVANTAGE PLAN
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	8009991147	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	8005627079	USE CODE 985 BENESIGHT
872	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. #200	MOLINE	IL	61215	8002246602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	8007778467	
B64	UNITED MEDICAL RESOURCES, INC.	PO BOX 30541	SALT LAKE CITY	UT	84130	5136193000	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	ROUTE 2 BOX 218A	BIG STONE GAP	VA	24219	8006549763	
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD.	ROCKVILLE	MD	20850	8002474144	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	8005198374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
721	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	8008808824	
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	8668808824	
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	8776175587	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	8665968447	
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	8003623308	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	8772429464	
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	8006171114	MEDICARE ADVANTAGE PLAN
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	8007470622	CODE ASSIGNED BY SCHA
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	8003668355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST. PETERSBURG	FL	33731	8666904842	MEDICARE ADVANTAGE PLAN
B93	UNIVERSITY HEALTH ALLIANCE	700 BISHOP ST., STE. 300	HONOLULU	HI	968134100	8005324000	
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	8778780914	
B68	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	MEDICARE ADVANTAGE PLAN
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	3154221533	
D85	US FIRE INSURANCE COMPANY	3195 LINWOOD RD., STE. 201	CINCINNATI	OH	45208	8005132981	
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	8002259674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
B55	US SCRIPTS	2425 WEST SHAW AVE.	FRESNO	CA	93711	8004608988	
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	CODE ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST., STE. 201	PHOENIX	AZ	85020	8008723860	CODE ASSIGNED BY SCHA
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	8005318222	
131	USI	PO BOX 9888	SAVANNAH	GA	31412	9126911551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
513	VALUE OPTIONS	PO BOX 1850	HICKSVILLE	NY	118021850	8002880882	
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	8009554879	USE CODE 333 EXPRESS SCRIPTS
633	VETERANS ADMINISTRATION						
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	8779344403	
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	8006227444	
606	VOCA.REHAB GENERAL						
608	VOCATIONAL REHAB DISABILITY						
E20	VRX PHARMACY SERVICES	PO BOX 9780	SALT LAKE CITY	UT	84109	8778799722	
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	8642772371	DORMANT 8/06
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	8668089399	
549	WAL-MART STORES GROUP HEALTH PLAN	922 W. WALNUT STE. A	ROGERS	AR	72756 320	5016212929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	8009470319	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	8003333841	CODE ASSIGNED BY SCHA
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU	WI	544028013	8008269781	
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	8007582851	
B13DN	WEB TPA	PO BOX 99906	GRAPEVINE	TX	76099	8007582851	
779	WEB-TPA AMERICAN FIDELITY ASSURANCE CO	PO BOX 99906	GRAPEVINE	TX	760999706	8663932872	DORMANT 8/06
C32	WELL FARGO INSURANCE	PO BOX 91608	LUBBOCK	TX	79490	8004354351	
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	8662352770	MEDICARE ADVANTAGE PLAN
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	8662311821	MEDICARE ADVANTAGE PLAN
F23	WELLDYNE RX	PO BOX 90369	LAKELAND	FL	33804	8884792000	
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	8005265710	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	5152454500	USE CARRIER CODE X2A
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	8005268995	
X2ADN	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 9354	DES MOINES	IA	503069354	8773330164	DENTAL
252	WELLNET HEALTHCARE	57 STREET RD.	SOUTH HAMPTON	PA	18966	8007271733	
A24	WELLPOINT NEXT RX	PO BOX 2902	CLINTON	IA	527332902	8009627378	USE CARRIER 333 EXPRESS SCRIPTS
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	8003376288	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	8883065299	
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST., STE. 200	PITTSBURGH	PA	15203	8448517293	DENTAL ONLY
C76	WESTERN AND SOUTHERN GROUPS	PO BOX 5735	CINCINNATI	OH	45201	8004248622	
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
969	WHP HEALTH INITIATIVE	PO BOX 968022	SCHAUMBERG	IL	601968022	8002072568	
F31	WILLIAM C. EARHART CO., INC.	PO BOX 97208	PORTLAND	OR	97208	8008460611	
F31DN	WILLIAM C. EARHART CO., INC.	PO BOX 4148	PORTLAND	OR	97208	8008460611	DENTAL ONLY
694	WILLIAMSBURG COUNTY						
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	8002558109	
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	4105470454	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANO	TX	750269025	8662705223	MEDICARE ADVANTAGE PLAN
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	8888588551	
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	6082769111	CODE IN OPEN STATUS BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	8889154158	
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD.	COLUMBIA	SC	292091639	8037764000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	8002253108	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	8003683429	DORMANT 8/06
622	WORKMEN'S COMP						
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	4024968000	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	8004564553	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	8667730404	
C51	YALEHEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	2034320250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
470	YODER BROTHERS	1001 LEBANON RD.	PENDLETON	SC	29670	8646468331	
695	YORK COUNTY						
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	8008417735	WAS PARADIGM CARE PLAN
977	ZENITH ADMINISTRATION	26359	LAS VEGAS	NV	89126	8004265980	DORMANT 8/06

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

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APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

Effective 01/01/19

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	8003334432	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST.	FOOTHILL RANCH	CA	92610	8779167920	ASSIGNED BY SCHA
102							
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	8667448482	CODE ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	8003903510	CODE ASSIGNED BY SCHA
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	8646091000	
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	8006548489	
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	8002289090	DO NOT USE FOR MED ADV. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	8006386626	
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	3366913000	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	8886323862	CODE ASSIGNED BY SCHA
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	8003463778	THIS CARRIER BOUGHT OUT BY AETNA CC100
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	7045443665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	8778423210	
114	CLAIMEDIX, INC.	PO BOX 140067	KANSAS CITY	MO	64114	8009224262	CODE ASSIGNED BY SCHA
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	8003668997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	8002558109	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	8642405840	
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	3013323000	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	8005358086	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	8008996803	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	7042258887	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	8437638680	
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	8006213724	
124	UNITED COMMERICAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	8008480123	
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	2152441600	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	8008610056	CODE ASSIGNED BY SCHA
127	BENEFITSOURCE, INC.	PO BOX 240	MONROE	MI	48161	8004231028	CODE ASSIGNED BY SCHA
128	CAPITOL LIFE INSURANCE COMPANY	PO BOX 1200	DENVER	CO	80201	8005252115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR., STE. 150	MALVERN	PA	19355	8005379389	
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	8889628437	CARRIER WAS COASTAL STATE LIFE INS. CO.
131	USI	PO BOX 9888	SAVANNAH	GA	31412	9126911551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	8037987000	
133	COMBINED INSURANCE COMPANY OF AMERICA	PO BOX 6700	SCRANTON	PA	18505	8002254500	
134	CIGNA	PO BOX 182223	CHATTANOOGA	TN	374227223	8008824462	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	8008257531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211		CODE ASSIGNED BY SCHA
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	7173972751	
138	LIFEWELL HEALTH PLANS	PO BOX 16203	LUBBOCK	TX	79490	8775433935	SUBSIDIARY OF HEALTHSCOPE
139	FISERV HEALTH	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	WAS WAUSAU INS. CO.
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010		MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE., PO BOX 3070	KNOXVILLE	TN	37927		
142	SC DEPT OF DISABILITIES AND SPECIAL NEEDS	PO BOX 4706	COLUMBIA	SC	29240	8038989795	CODE ASSIGNED BY SCHA
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	9725406542	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	9419366242	
146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	7045366230	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	8887806388	
148	TRANSAMERICA PREMIER LIFE INSURANCE COMPANY	PO BOX 742502	CINCINNATI	OH	45274	8004445431	
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	2126184000	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	8008882452	
151	CARELINK	PO BOX 7373	LONDON	KY	40742	8003482922	MEDICAID HMO
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	8009523455	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
154	CONSUMER DRN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	8884114208	CODE ASSIGNED BY SCHA
155	CROSSAMERICA HEALTH PLAN	PO BOX 5778	PARSIPPANY	NJ	07054	8663027332	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	8042816000	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	8004232765	
159	MAKSIN MANAGEMENT CORP	CN98000	PENNSAUKEN	NJ	08110	8002570625	
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	8772179677	WAS MASS MUTUAL
161	AMA INSURANCE AGENCY, INC.	PO BOX 804238	CHICAGO	IL	60680	8004585736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	8004213550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	6142497111	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	8006268913	
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	8003884580	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	2166966400	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 26050	OVERLAND PARK	KS	66225	8887221668	
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	5163906000	
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	8645856456	
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	9198318189	
171	AON	PO BOX 66	WINSTON-SALEM	NC	27102	8003683804	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	5087994441	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	8002757366	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	2123374900	
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	5123453200	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	8005956949	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD. #332	LAKE HIAWATHA	NJ	080341997	8008471148	CODE IN OPEN STATUS BY SCHA
178	INSURANCE & BENEFIT ADVOCATE, INC.	5838 W BRICK RD STE. 106	SOUTH BEND	IN	46628	8662006700	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	8007773622	
180	ESIS	PO BOX 31122	TAMPA	FL	33631	8008847975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	8475191880	
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	8003620700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	8002342643	
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 82520	LINCOLN	NE	68501	8003009566	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	8888008717	
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82510	LINCOLN	NE	68501	8004977044	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	8035483657	
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	8664337462	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	9133426555	
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	8008337423	
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	8002883343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	8009377039	
194	DAKOTACARE	PO BOX 7406	SIOUX FALLS	SD	571177406	8003255598	CODE ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	2149547840	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST.	FT. WORTH	TX	76107	8007320657	
197	RELIANCE STANDARD SPECIALTY PRODUCTS ADM	505 S LENOLA RD., STE. 231	MOORESTOWN	NJ	08057	8663750775	
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	8003668355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
199	ALL OTHER CARRIERS						
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	7733996645	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	8002331449	
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	8005544022	CODE ASSIGNED BY SCHA
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	7275320400	
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	8006488624	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON-SALEM	NC	271145307	8007951023	
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST.	MIDDLETON	NY	10940	3173298222	
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	8002524624	
209	SUMMIT AMERICA INSURANCE SERVICES	PO BOX 25936	OVERLAND PARK	KS	662255936	8772466997	
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	8002559678	
211	COORDINATED BENEFIT PLANS, INC.	PO BOX 853925	RICHARDSON	TX	750853925	8007531000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	8476151500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50 EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	7702396230	
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	8007703740	
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	8774693073	
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	8004574708	
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	8776175587	
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	8884792000	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	8008379600	RX CARRIER ONLY
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE, STE 1500	SPRINGFIELD	MA	011441500	8003102835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	8009926613	
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	8009523455	
223	MED COST PREFERRED	PO BOX 25437	WINSTON-SALEM	NC	27114	8008247406	CODE ASSIGNED BY SCHA
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	4238992593	
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	5104497070	
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	7068635955	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	8007529797	
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	8005455015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
229	SELF INSURED PLANS LLC	1016 COLLIER CENTER WAY STE. 200	LOS ANGELES	CA	90080	8004212342	CODE ASSIGNED BY SCHA
230	PYRAMID LIFE INSURANCE COMPANY	P O BOX 130	PENSACOLA	FL	32591	8004440321	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD., STE. 201	WINSTON-SALEM	NC	27106	8006420483	
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ATLANTA	GA	30366	4044579555	CODE ASSIGNED BY SCHA
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	8006880010	
234	ALWAYSCAREBENEFITS, INC.	PO BOX 80139	BATON ROUGE	LA	70898	8887295433	DENTAL PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	8003211855	
236	GUARANTEE TRUST LIFE INSURANCE	PO BOX 1144	GLENVIEW	IL	60025	8476990600	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	P O BOX 981572	EL PASO	TX	799981572	6108076000	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	8007923666	
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	2177892500	
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	8003085948	POLICIES BEGINNING WITH "R" NEED TO BE "E" INDICATORS AND GO TO PO BOX 188004, CHATTANOOGA, TN 37422. POLICIES WITH PH SSN STAYS AS "C".
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	8002291024	
242	HELLER ASSOCIATES	8228 MAYFIELD RD., STE. 5B	CHESTERLANDE	OH	44026	4405272955	CODE IN OPEN STATUS BY SCHA
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	6157491000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	8776045240	
245	COVENTRY OF THE CAROLINA'S	PO BOX 7102	LONDON	KY	40742	8009357284	
246	COVENTRY HEALTH CARE RX	PO BOX 8400	LONDON	KY	40742	8009476824	
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	8008729934	CARRIER WAS FIRST INTEGRATED HEALTH
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD.	NORTH OLMSTED	OH	440705300	8002558063	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	8005544954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
250	IDEAL SCRIPTS	50 WHITE CAP DR.	NORTH KINGSTOWN	RI	02886	8007176614	
251	PYRAMID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	8006581413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
252	WELLNET HEALTHCARE	57 STREET RD.	SOUTH HAMPTON	PA	18966	8007271733	
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	8772926037	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	8004512513	
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 981644	EL PASO	TX	79998	8006949888	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
256	BENICOMP	8310 CLINTON PARK DR.	FT. WAYNE	IN	46825	8008377400	CODE ASSIGNED BY SCHA
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD., STE. 101	RALEIGH	NC	27609	8003317108	SEE CARRIER 366 CATALYST RX
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	8883222524	
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	8005083772	
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	8662199292	CODE IN OPEN STATUS BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	8003153440	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	8887302244	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST., STE. 300	FT WORTH	TX	76102	8007251407	
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	8007888445	
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	8662225137	MEDICARE ADVANTAGE PLAN
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	8002326242	
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	7043643865	CODE ASSIGNED BY SCHA
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	8009348203	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	8002556065	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	PO BOX 220397	CHARLOTTE	NC	28222	8666360239	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	22OO-B ROSSELLE ST.	JACKSONVILLE	FL	32204	8004685126	
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	8003423289	
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	8007725924	CODE ASSIGNED BY SCHA
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	8009267526	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	9134514900	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	8005385512	
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	9725295085	
278	ROCKY MOUNTAIN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	8008544558	
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	8007778467	
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	8008415550	USE CARRIER 471
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	8003371421	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	8009470319	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	8668501256	MEDICARE ADVANTAGE PLAN
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	8003454017	
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	8002253108	
286	HEALTH EXCHANGE (TPA FOR CERNER HEALTH)	PO BOX 165750	KANSAS CITY	MO	64116	8002314015	CODE IN OPEN STATUS BY SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	8888008717	
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	8002060827	
289	AFTRA HEALTH FUND	261 MADISON AVE.	NEW YORK	NY	10016	8005624690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOX 31716	TAMPA	FL	336313716	8134968100	
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	7037294677	
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	8005265710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	8888912564	
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	8002378447	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	6082731776	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	8006549106	
297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	2124735700	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	8002474526	
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	2125395115	
300	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
301	BENEFIT PLAN ADMINISTRATORS	PO BOX 21392	EAGEN	MN	55121	8002778973	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	8162575500	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	5023397500	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	8669272200	
305	HEALTHSMART	PO BOX 91608	LUBBOCK	TX	79490	8668695597	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	8004438087	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	8665131479	
308	GREAT WEST LIFE	PO BOX 188061	CHATTANOOGA	TN	374228061	8006638081	GREAT WEST/CIGNA
309	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	6304939252	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	8007425246	
311	BENEFIT PLANNERS, INC.	PO BOX 682010	SAN ANTONIO	TX	78269	2106991872	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR.	KENNETT	MO	63857	8006638081	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	8887275560	SEE CARRIER 366 CATALYST RX
315	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD.	RALEIGH	NC	27607	8002891122	
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	8005520455	
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	3308678443	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	8002202600	
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	6019493100	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	8002222798	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	8005537654	USE 386 ASSURANT HEALTH
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	8885868810	
324	HEALTH REIMBURSEMENT MANAGEMENT PARTNERSHIP	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	8004311211	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	8008329186	
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	8004107778	
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	8667747766	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	8008095916	
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	2147200511	
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	8005412254	
332	HEALTH PLANS, INC.	PO BOX 5199	WESTBOROUGH	MA	01581	8005327575	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
333	EXPRESS SCRIPTS	PO BOX 14713	LEXINGTON	KY	40512	8004516245	
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	8006388432	
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	4402504300	
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN)	PO BOX 968022	SCHAUMBERG	IL	60196	8009626294	
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	8007737752	
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	8002381344	
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	8004777870	
340	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVENUE OF THE CITIES, STE. 200	MOLINE	IL	61265	8002246602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
341	ADMINISTRATIVE CONCEPTS, INC.	994 OLD EAGLE SCHOOL RD., STE. 1005	WAYNE	PA	19087	8882939229	
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	8002253950	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	2013433003	
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	8008825707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
345	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLD #9	TUCKER	GA	30084	7709343953	
347	PREFERRED CARE, INC. (PCI)	1300 VIRGINIA DR., STE. 315	FORT WASHINGTON	PA	19034	8002223085	
348	FIRST AGENCY, INC.	5071 WEST H AVE.	KALAMAZOO	MI	490098501	2693816630	THIS CODE ASSIGNED BY SCHA 8/28/07
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	8002936260	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	6152563561	
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	8666848090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	8004468182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	8003149010	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015		CODE ASSIGNED BY SCHA
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	6024689500	
356	UMR	PO BOX 2697	WICHITA	KS	67201	8008269781	USE CODE 139
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630	8002377767	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE. STE. 300	KENSINGTON	MD	208953960	3014683742	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	9196829201	
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	8004087681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE. 310	PONTE VEDRA BEACH	FL	32082	8008416288	CODE ASSIGNED BY SCHA
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	8668501253	MEDICARE ADVANTAGE PLAN
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	8886226001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	8004446965	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	8649875200	
366	CATALYST RX	PO BOX 968022	SCHAUMBERG	IL	601968022	8009973784	
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	8007820392	
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	2192370560	
369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	8004687077	
370	DELTAHEALTH SYSTEMS	PO BOX 9554	SALT LAKE	UT	84109	8774740605	WAS P5 HEALTH PLUS SOLUTIONS
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	8006589777	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	9736963111	
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD.	WINTER HAVEN	FL	338880007	8633183000	
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	8003319955	
375	RESTAT	11900 WESTLAKE PARK DR.	MILWAUKEE	WI	53224	8009265858	
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	8004620224	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
377	MERITAIN HEALTH	PO BOX 27267	MINNEAPOLIS	MN	554270267	8009252272	WAS NORTH AMERICAN ADMINISTRATORS, INC.
378	SELF INSURERS SERVICE, INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282		
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	2167966531	
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	6013660596	
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	8005199175	
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	8007771840	MEDICARE ADVANTAGE PLAN
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	8772840102	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	8003214085	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	7036835585	
386	ASSURANT HEALTH	PO BOX 624	MILWAUKEE	WI	532010624	8005537654	WAS FORTIS INSURANCE COMPANY
387	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	HEALTHGRAM FORMERLY PRIMARY PHYSICIAN CARE
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	8008107856	
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	8003597408	
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	6123337651	
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	8002344393	
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	8003421895	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	8009919155	
394	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE CITY	UT	84109	8774740605	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
395	PINNACLE CLAIMS MANAGEMENT, INC.	1630 E SHAW AVE., STE. 190	FRESNO	CA	93710	8006499121	CODE ASSIGNED BY SCHA
396	MACY'S HR SERVICES	PO BOX 850958	RICHARDSON	TX	75085	8003372363	CODE ASSIGNED BY SCHA
397	PRIME THERAPEUTIC	PO BOX 25136	LEHIGH VALLEY	PA	18002	8886420447	
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD., STE. 100	ST. LOUIS	MO	63127	8003659036	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	8007332285	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8008682520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	8037883860	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. STREET ADDRESS 4101 Percival RD. COLA 29219
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	8037883860	
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICAID HMO
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	8643701800	
405	MARSH(INSURANCE TRUST PLAN-DELTA RETIREES)	PO BOX 10432	DES MOINES	IA	503060432	8773257265	CODE ASSIGNED BY SCHA
406	RURAL CARRIER BENEFIT PLAN	PO BOX 7404	LONDON	KY	40742	8006388432	
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	8008471148	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	5013760426	AKA AEGON
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	3154221533	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	2068678000	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	8665114757	CODE ASSIGNED BY SCHA
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	8002517722	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786-60690	CHICAGO	IL	606909786	8002882078	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	8282529776	
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	8008681032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
417	JULY PRODUCTS	5 GATEWAY CENTER STE 60	PITTSBURG	PA	15222	8669008322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	8006854542	CODE ASSIGNED BY SCHA
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	8006266402	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	6082385851	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
421	UNITED FOOD & COMMERICAL WORKER HEALTH&WELFARE	911 RIDGEBROOK RD.	SPARKS	MD	211529451	8006382972	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
432	M-PLAN CARDINAL HEALTH	PO BOX 357	LINTHICUM	MD	210900357	8006752605	CODE ASSIGNED BY SCHA
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	8037880500	
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	8643759661	
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	8005822498	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	8037320060	
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	2813687200	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDERICK	MD	21705	8002576458	
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	8004446254	USE 386 ASSURANT HEALTH
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	8006417761	
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	8005220041	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	8002530856	
443	COVENTRY HEALTHCARE OF KANSAS	PO BOX 7109	LONDON	KY	39026	8667858077	CODE ASSIGNED BY SCHA
444	NATIONAL DISASTER MEDICAL SYSTEM						
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	8003153143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	8035778051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	9004387886	MEDICARE ADVANTAGE PLAN
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	8005537654	CODE ASSIGNED BY SCHA
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	8008721187	CODE ASSIGNED BY SCHA
450	DESERET SECURE	PO BOX 45530	SALT LAKE CITY	UT	841450530	8772200110	MEDICARE ADVANTAGE PLAN
451	ASSURECARE RISK MANAGEMENT	340 QUADRANGLE BLVD.	BOLINGBROOK	IL	60440	8007597422	
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	8004412668	
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	8006762583	MEDICARE ADVANTAGE PLAN
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	9085486662	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE., STE. 107	ANCHORAGE	AK	995034116	8004784450	CODE ASSIGNED BY SCHA
456	FIRST HEALTH (A COVENTRY HEALTH CARE CO)	PO BOX 21680	EAGAN	MN	551210680	8664775465	
457	COMMERICAL TRAVELERS	70 GENESSE ST.	UTICA	NY	13502	8007563702	CODE ASSIGNED BY SCHA
458	ASSOCIATION BENEFIT PLAN (MEDICARE)	PO BOX 668587	CHARLOTTE	NC	282668587	8006340069	CODE ASSIGNED BY SCHA
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	8139366242	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	3175549000	
461	EVERCARE	PO BOX 31350	SALT LAKE CITY	UT	841310350	8888668298	MEDICARE ADVANTAGE PLAN
462	1ST MEDICAL NETWORK	PO BOX 724317	ATLANTA	GA	31139	8889806676	CODE ASSIGNED BY SCHA
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	7176324727	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	8006284664	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	3037705710	
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	8009554879	USE CODE 333 EXPRESS SCRIPTS
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	8008482664	USE CODE 139
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	8003976241	
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	8005235880	
470	YODER BROTHERS	1001 LEBANON RD.	PENDLETON	SC	29670	8646468331	
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	8003030187	
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN (NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	6158902020	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	8042191585	CODE ASSIGNED BY SCHA
474	DIVERSIFIED PHARMACEUTICAL	PO BOX 169052	DULUTH	MN	55816	8002338065	USE CODE 333 EXPRESS SCRIPTS
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	3045621913	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 981606	EL PASO	TX	79998	8005272845	
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	8008672582	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	8004334893	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	8008891947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
481	BENOVATION	3481 CENTRAL PARKWAY, STE. 200	CINCINNATI	OH	45223	8006816912	CODE ASSIGNED BY SCHA
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	8667321017	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	4024839250	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	7704281604	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	8006283912	CODE ASSIGNED BY SCHA
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	MEDICARE ADVANTAGE PLAN
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	8434235541	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE. NORTHWEST	NORTH CANTON	OH	44720	3309665500	
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	8003506714	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	8002482141	CODE ASSIGNED BY SCHA
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	8006227444	
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD.	MINNEAPOLIS	MN	55305		CODE ASSIGNED BY SCHA
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	8668808824	
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST., STE. 300	PHOENIX	AZ	85012	6022413400	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	8005226727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	8006216360	
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON-SALEM	NC	27116	8663074711	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	8645736937	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	8005587798	
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	8005212651	
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	8005236599	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	8004478255	MEDICARE ADVANTAGE PLAN
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD., BLDG. TWO	MOORESTOWN	NJ	08057	8003597475	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	2156578920	CODE IN OPEN STATUS BY SCHA
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	8006382972	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	EXETER	NH	03833	8002587298	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	4023971111	
508	GROUP HEALTH, INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	2125014444	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	8003525150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	8007492631	
511	CIGNA BEHAVIORAL HEALTH	PO BOX 188022	CHATTANOOGA	TN	37422	8003364091	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE.	MIAMI SHORES	FL	33138		CODE ASSIGNED BY SCHA
513	VALUE OPTIONS	PO BOX 1850	HICKSVILLE	NY	118021850	8002880882	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	8007933773	NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	8006616385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR., STE. 420	ALPHARETTA	GA	30202	7706645594	
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	8007626004	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
518	NAT'L ASBESTOS WORKERS MED FUND	PO BOX 188004	CHATTANOOGA	TN	37422	8003863632	
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	8778939294	
520	NEW JERSEY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	8006243096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	8002350123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	3015771700	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	8008333650	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	8004778957	CODE ASSIGNED BY SCHA TPA
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	8009470319	USE CODE 282 WASHINGTON NATIONAL

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	8003448858	
528	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	8006111811	MEDICARE ADVANTAGE PLAN
529	ANTHEM HEALTH	3575 KROGER BLVD., STE. 400	DULUTH	GA	30316	8008881966	
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	8007470622	CODE ASSIGNED BY SCHA
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR.,	SPARTANBURG	SC	29307	8645733535	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREEN BAY	WI	543079032	8002325432	
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	8883239271	
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	2627844600	
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	8007731445	
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	8006348816	CODE ASSIGNED BY SCHA
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	8004441535	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	8003621279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	2053252722	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPARTANBURG	SC	293054217	8645962227	CODE ASSIGNED BY SCHA
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	8006315917	
543	ACHA/CAREINGTON INTERNATIONAL CORP	PO BOX 2568	FRISCO	TX	75034	8002900523	CODE ASSIGNED BY SCHA
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONG BEACH	CA	90801	8006424148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
546	RISK MANAGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	3154489000	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	8777370769	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	8005940977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
549	WAL-MART STORES GROUP HEALTH PLAN	922 W. WALNUT STE. A	ROGERS	AR	72756 320	5016212929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
550	EMPLOYEE SECURITY, INC.	7125 THOMAS EDISON DR., STE. 105	COLUMBIA	MD	21046	8006381134	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	8668734516	CODE IN OPEN STATUS BY SCHA
552	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
553	HEALTHSCOPE BENEFITS, INC..	PO BOX 99005	LUBBOCK	TX	79490	8883736102	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	4236396145	
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	8005527879	CODE ASSIGNED BY SCHA
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	8666994186	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	8002325818	INACTIVE 8/02
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	8436613875	
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	8008255406	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	8004512513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
562	HEALTH CLAIMS SERVICES,INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	8002223560	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG. D	BROADVIEW HEIGHTS	OH	44147		
564	MULTINATIONAL UNDERWRITERS	PO BOX 863	INDIANAPOLIS	IN	46206	8006052282	CODE ASSIGNED BY SCHA
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	8004344890	WAS POE & BROWN
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E	EAST ORANGE	NJ	07018	8005240227	
568	SIMPLIFI	PO BOX 922043	HOUSTON	TX	772922043	8884465710	FORMERLY CBCA ADMINISTRATORS
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	8009538854	CODE IN OPEN STATUS BY SCHA
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD.	ROCKVILLE	MD	20852	8006386589	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	8886049397	CODE IN OPEN STATUS BY SCHA
572	CATAMARAN	PO BOX 29044	HOT SPRINGS	AR	71093	8778398119	FORMERLY HEALTH TRANS
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	8778757700	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	8063784235	CODE IN OPEN STATUS BY SCHA
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	6082769111	CODE IN OPEN STATUS BY SCHA
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	8007525863	
577	HEALTHMARKETS CARE ASSURED	PO BOX 69349	HARRISBURG	PA	17110	8772195460	CODE ASSIGNED BY SCHA
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD., STE. 100	ORLANDO	FL	32814	8007410521	
579	ANTHEM PRESCRIPTION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	8006620210	USE CARRIER A24
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	4024968000	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	8009985033	
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	8005318222	
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	8008246796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
584	UNITED HEALTH ONE	PO BOX 31374	SALT LAKE CITY	UT	841310374	8006578205	FORMALLY GOLDEN RULE
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST.	PEEKSILL	NY	10566	9147377220	
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD.	PITTSBURGH	PA	15220	4129220780	WAS DIVERSIFIED GROUP ADMINISTRATORS
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	8886787012	
588	AUTOMATED BENEFIT SERVICES, INC.	PO BOX 321223	DETROIT	MI	482321223	8002751896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
589	POLY AMERICA LP	2000 W MARSHALL DR.	GRAND PRAIRIE	TX	75051	8007855301	CODE IN OPEN STATUS BY SCHA
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	8008484747	
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	8167534900	
592	CONTEC	525 LOCUS GROVE RD.	SPARTANBURG	SC	29303	8645038333	CODE ASSIGNED BY SCHA
593	MUTUAL ASSURANCE ADMINISTRATORS, INC.	PO BOX 42096	OKLAHOMA CITY	OK	73123	8006489652	
594	NORWEST FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	5152432131	CODE ASSIGNED BY SCHA
595	AFLAC-AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	8009923522	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	8665798811	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	8006289000	
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD.	COLUMBIA	SC	292091639	8037764000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	8005234702	
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC			
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	3033317599	
606	VOCA.REHAB GENERAL						
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	8667730404	
608	VOCATIONAL REHAB DISABILITY						
609	COMM FOR BLIND						
610	DHEC CANCER						
611	DHEC C. CHILDREN						
612	DHEC LOW RISK MATERNITY						
613	DHEC HIGH RISK MATERNITY						
614	TRICARE WEST	PO. BOX 202112	FLORENCE	SC	295022112	8004033950	INTERNET WWW.TRICARE-WEST.COM
615	DHEC STERILIZATION						
616	MEDICAID-OUT-OF-STATE						
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	8772887600	
618	MEDICARE PART A						
619	MEDICAID, SC						
620	MEDICARE PART B ONLY						
621	DEPT CORRECTIONS						
622	WORKMEN'S COMP						
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	8037507473	MEDICARE ADVANTAGE PLAN
624	OTHER SPONSOR						
625	DHEC MIGRANT HEALTH						
626	DHEC SICKLE CELL						
627	DHEC HEART						
628	DHEC HEMOPHILIA						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
629	DHEC FAMILY PLANNING						
630	DHEC TB						
631	SHRINERS						
632	CRIME VICTIMS						
633	VETERANS ADMINISTRATION						
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	4023427600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		MEDICARE INTERMEDIARY PART B
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	8882762020	MEDICAID HMO
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	MEDICAID HMO
639	HEALTHFIRST HMO	255 ENTERPRISE BLVD., STE. 20	GREENVILLE	SC	29615	8644551100	MEDICAID HMO
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	8667730404	
643	BCBS OF TENNESSEE	730 CHESTNUT ST.	CHATTANOOGA	TN	37402	8772966189	MEDICARE INTERMEDIARY
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	8004412273	MEDICARE INTERMEDIARY
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	6152445600	MEDICARE ADVANTAGE PLAN
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	6152445600	MEDICARE INTERMEDIARY
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	8775115000	MEDICARE ADVANTAGE PLAN
650	ABBEVILLE COUNTY						
651	AIKEN COUNTY						
652	ALLENDALE COUNTY						
653	ANDERSON COUNTY						
654	BAMBERG COUNTY						
655	BARNWELL COUNTY						
656	BEAUFORT COUNTY						
657	BERKELEY COUNTY						
658	CALHOUN COUNTY						
659	CHARLESTON COUNTY						
660	CHEROKEE COUNTY						
661	CHESTER COUNTY						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
662	CHESTERFIELD COUNTY						
663	CLARENDON COUNTY						
664	COLLETON COUNTY						
665	DARLINGTON COUNTY						
666	DILLON COUNTY						
667	DORCHESTER COUNTY						
668	EDGEFIELD COUNTY						
669	FAIRFIELD COUNTY						
670	FLORENCE COUNTY						
671	GEORGETOWN COUNTY						
672	GREENVILLE COUNTY						
673	GREENWOOD COUNTY						
674	HAMPTON COUNTY						
675	HORRY COUNTY						
676	JASPER COUNTY						
677	KERSHAW COUNTY						
678	LANCASTER COUNTY						
679	LAURENS COUNTY						
680	LEE COUNTY						
681	LEXINGTON COUNTY						
682	MARION COUNTY						
683	MARLBORO COUNTY						
684	MCCORMICK COUNTY						
685	NEWBERRY COUNTY						
686	OCONEE COUNTY						
687	ORANGEBURG COUNTY						
688	PICKENS COUNTY						
689	RICHLAND COUNTY						
690	SALUDA COUNTY						
691	SPARTANBURG COUNTY						
692	SUMTER COUNTY						
693	UNION COUNTY						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
694	WILLIAMSBURG COUNTY						
695	YORK COUNTY						
696	OUT-OF-STATE GA						
697	OUT-OF-STATE NC						
698	OUT-OF-STATE OTHER						
700							
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	8002888630	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	CODE ASSIGNED BY SCHA
702DN	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	DENTAL ONLY
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	7045259666	
704	UNITED FOOD & COMMERICAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	8002417701	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	8002218699	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	8887412673	
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD.	DILLON	SC	29536	8437747353	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	8885547629	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	8008687526	
710	21ST CENTURY HEALTH AND BENEFITS, INC.	PO BOX 5037	CHERRY HILL	NJ	08034	8003234890	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	4044771888	
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	8005815300	CARRIER BOUGHT OUT BY PHARMACARE CC 740
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	8663736366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	8005337896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	8005262414	USE CC113 UNITED HEALTHCARE
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	8884463327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	CODE ASSIGNED BY SCHA
718	CIGNA PHARMACY SERVICES	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	9043548335	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	ROUTE 2 BOX 218A	BIG STONE GAP	VA	24219	8006549763	
721	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	8002472190	
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	8032566265	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	8004484689	CODE ASSIGNED BY SCHA
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	8645852046	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	8008783157	
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	8004624660	
728	GENERAL PRESCRIPTION PROGRAMS, INC.	305 MADISON AVE. STE 1166B	NEW YORK	NY	10165	8003412234	
729	U.A. LOCAL 446 PLUMBERS AND PIPEFITTERS	PO BOX 191030	SACRAMENTO	CA	958191030	9164570821	CODE IN OPEN STATUS BY SCHA
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	8005666710	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	8664704959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
732	HERTZ CLAIM MANAGEMENT	PO BOX 726	PARK RIDGE	NJ	07656	2013072177	
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	2084527979	CODE IN OPEN STATUS BY SCHA
734	STRATEGIC OUTBURSTING, INC.	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
735	INTEGRITAS BENEFIT GROUP	PO BOX 1447	CORDOVA	TN	38088	9016858980	
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	8006383120	
737	UNITED CONCORDIA	PO BOX 69451	HARRISBURG	PA	17106	8003320366	
738	FHA-TPA DIVISION	PO BOX 327810	FT. LAUDERDALE	FL	333329711	8037988698	CODE IN OPEN STATUS BY SCHA
739	BOLLINGER, INC.	PO BOX 727	SHORT HILLS	NJ	07078	8662670092	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	8002376184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE ASSIGNED BY SCHA
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	8009376432	
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT. WAYNE	IN	468012362	2606257500	
744	SENIOR DIMENSIONS	PO BOX 15645	LAS VAGAS	NV	891145645	8009257455	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	8006386085	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	8003479355	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	8663169776	CODE ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209		CODE ASSIGNED BY SCHA
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	8002533074	
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	8159699663	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	8002340225	
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	8005912650	CODE ASSIGNED BY SCHA
753	HEALTHNET	PO BOX 2226	AUGUSTA	GA	309032226	9009778221	
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	6464739200	
755	TOTAL BENEFIT SERVICES, INC.	PO BOX 30180	NEW ORLEANS	LA	70190		
756	INSURANCE MANAGEMENT ADMINISTRATORS (IMA)	PO BOX 71120	BOSSIER CITY	LA	711719944	8007429944	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	9728816000	
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	8004892974	CODE ASSIGNED BY SCHA
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	8002472192	AKA TROA
760	KEY BENEFIT ADMINISTRATORS	PO BOX 3253	MILWAUKEE	WO	53201	8003314757	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE., STE. 235	KALAMAZOO	MI	49007	8003257477	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	8778158857	CODE ASSIGNED BY SCHA
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	8005257268	
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	8003482922	
765	FREEDOM HEALTH	PO BOX 151348	TAMPA	FL	33684	8004012740	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
767	HEALTHSCOPE BENEFITS	PO BOX 619055	DALLAS	TX	752619055	8006006212	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	8889154158	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	8008744723	
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	8005237900	
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	8176566040	USE CODE 477 MEGA LIFE
772	BENEFIT SYSTEMS, INC.	PO BOX 6001	INDIANAPOLIS	IN	462066001	8008243216	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX 2018	OMAHA	NE	681032018	8002289100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
774	MOLINA MEDICARE OPTIONS PLUS	PO BOX 22811	LONG BEACH	CA	90801	8006651328	MEDICARE ADVANTAGE PLAN
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	8003035770	
776	AFID (ASSO. OF FRANCHISE AND INDEPENDENT DIST.)	1 S. LIMESTONE ST., STE. 301	SPRINGFIELD	OH	45502	8667669016	CODE IN OPEN STATUS BY SCHA
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	8002259674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
778	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 14770	LEXINGTON	KY	40512	8002644000	
779	WEB-TPA AMERICAN FIDELITY ASSURANCE CO	PO BOX 99906	GRAPEVINE	TX	760999706	8663932872	DORMANT 8/06
780	CORPORATE SYSTEMS ADMINISTRATION, INC.	PO BOX 4985	JOHNSON CITY	TN	376024985	8002752847	
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 25307	WINSTON-SALEM	NC	271145307	8003340609	
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	8009372036	
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	8007766070	CODE ASSIGNED BY SCHA
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	8002530856	CODE ASSIGNED BY SCHA
786	ACS BENEFIT SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	8008495370	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	8008513802	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
788	TRANSAMERICA LIFE INSURANCE CO.	PO BOX 97	SCRANTON	PA	185040097	8008203372	CODE ASSIGNED BY SCHA
789	FIRST COMMUNITY HEALTH PLAN, INC.	PO BOX 382947	BIRMINGHAM	AL	35238	8007347826	CODE IN OPEN STATUS BY SCHA
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	8007527242	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	8665968447	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	8159875000	USE CODE 282 WASHINGTON NATIONAL
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	8004574708	MEDICARE ADVANTAGE PLAN
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	4046593300	
795	REGIONAL MEDICAL ADMINISTRATORS, INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	3362267950	
796	LINECO	821 PARKVIEW BLVD.	LOMBARD	IL	601483230	8003237268	CODE ASSIGNED BY SCHA
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	8664225009	MEDICARE ADVANTAGE PLAN
798	MEDCARE INTERNATIONAL	12480 WEST ATLANTIC BLVD., STE. 2	CORAL SPRINGS	FL	33071	9543455650	
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	8008764582	WAS GE FINANCIAL SERVICES
800	NEBCO (TENNECO)	PO BOX 97	SCRANTON	PA	185040097	8007177562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	8882738020	
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	8007896364	
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	8005381235	
804	PIEDMONT COMMUNITY HEALTHCARE, INC.	PO BOX 14408	CINCINNATI	OH	452500408	8004007247	
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	8006357418	CODE ASSIGNED BY SCHA
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	9207201300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	8002291199	
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	8005706745	
809	INTER VALLEY HEALTH PLAN	300 SOUTH PARK, PO BOX 6002	POMONA	CA	917696002	8002518191	CODE ASSIGNED BY SCHA
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	8778013507	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721		CODE ASSIGNED BY SCHA
812	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
813	CENTURY PLANNER	9201 WATSON RD., STE. 350	ST. LOUIS	MO	631261509	8007762453	
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	8004427247	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANO	TX	75026	8664587499	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
817	PRIORITY HEALTH	PO BOX 232	GRAND RAPIDS	MI	49501	8004465674	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	8002524674	
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	8009826257	CODE ASSIGNED BY SCHA 6/07/10
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	8006356671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	8773370650	
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	8002582873	CODE ASSIGNED BY SCHA
823	HEALTH ALLIANCE PLAN	PO BOX 02459	DETROIT	MI	48202	8004224641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
824	ENVISION RX OPTIONS	2181 EAST AURORA RD., STE. 201	TWINSBURG	OH	44087	8003614542	
825	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 8207	KINGSTON	NY	12402	8006009007	MEDICARE ADVANTAGE PLAN
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	4105470454	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	8882954864	
828	NATIONAL PHARMACEUTICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	8005465677	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	6783390211	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	8002477724	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	8886049397	
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	8003879919	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	8006472240	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	8663334648	BROUGHT OUT BY UNITED HEALTHCARE CARRIER 113
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	8006729540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
836	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	8008655440	
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST. PAUL	MN	55116	8883308408	
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	5022442420	
840	AMERICAN, INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	8177723050	
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	8003333841	CODE ASSIGNED BY SCHA
842	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	8887412673	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	8006177446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	8004989731	MEDICARE ADVANTAGE PLAN
846	SCRIPT CARE, INC.	6380 FOLSOM DR.	BEAUMONT	TX	77706	8008809988	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	8002807093	
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	8002822460	
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	8884568417	
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	8003423289	CODE ASSIGNED BY SCHA
852	BUILDERS MUTUAL INSURANCE CO	PO BOX 150006	RALEIGH	NC	276240006	8008094861	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	8775955282	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	3347751284	
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	8778780914	
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	2137422111	
857	CORPORATE BENEFIT SERVICES, INC.	PO BOX 211778	EAGAN	MN	55121	7043730447	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	8003076553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	8006541731	
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	8008352094	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	8772917920	
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	8777776076	
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	8008433106	
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	8882558961	
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	8002349009	NAIC 93742
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	3607349888	
867	BCBS OF NC	PO BOX 30087	DURHAM	NC	27702	9194897431	
868	KANSAS CITY LIFE	PO BOX 9040	AUSTIN	TX	78766	8008745254	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	8007773575	
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	8004415501	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	8008776003	CODE ASSIGNED BY SCHA
872	UNITED HEALTHCARE PLAN OF RIVER VALLEY	3800 23RD AVE. #200	MOLINE	IL	61215	8002246602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	8002217006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	8887477823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	8006927338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
876	HEALTHSOURCE OF NC, INC.	PO BOX 28087	RALEIGH	NC	27611	8008499000	USE CODE 134 CIGNA HEALTHCARE
877	PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)	PO BOX 300	INDEPENDENCE	MO	640510300	8002207898	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
878	HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	8002530966	
879	COVENTRY OF THE CAROLINAS	PO BOX 7102	LONDON	KY	40742	8662083610	FORMALLY WELLPATH
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	8642134992	
881	BEHAVIORAL HEALTH SYSTEMS	PO BOX 830724	BIRMINGHAM	AL	352830724	8002451150	
882	CONNECTICARE	PO BOX 4000	FARMINGTON	CT	06034	8772248230	CODE ASSIGNED BY SCHA
883	SELECT HEALTH OF SOUTH CAROLINA, INC.	7410 NORTHSIDE DR., STE. 208	CHARLESTON	SC	29420	8435691759	CODE IN OPEN STATUS BY SCHA
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	8007167737	CODE IN OPEN STATUS BY SCHA
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
886	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	8004267453	
888	SOUTHEASTERN BENEFIT PLANS, INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	7045295400	
889	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON-SALEM	NC	271167368	8009425695	
891	OPTIMUM CHOICE OF THE CAROLINAS, INC.	4 TAFT CT.	ROCKVILLE	MD	20850	8003438205	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8002471466	
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	8002273116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	8889917200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	8002644000	
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE. 1	NEWTOWN	PA	18940	8004828770	
897	SOUTHERN BENEFIT ADM.	PO BOX 188006	CHATTANOOGA	TN	37422	8006784656	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
899	AETNA HEALTH PLANS OF THE CAROLINAS, INC.	3 CENTERVIEW DR.	GREENSBORO	NC	27407	8004591466	HMO PLAN ONLY
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	9204574441	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	8003679466	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
902	BLUE CARE NETWORK OF MI	PO BOX 68710	GRAND RAPID	MI	49516	8006588878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
903	CAREPLUS HEALTH PLAN	PO BOX 31286	TAMPA	FL	336313286	8008674445	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	8008674446	
905	GERBER LIFE MEDICARE SUPPLEMENT	PO BOX 2271	OMAHA	NE	68103	8776565425	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
906	GROUP HEALTH ADMINISTRATOR, INC.	PO BOX 6244	CHARLOTTE	NC	282071018	8002225790	
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	8007662525	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	8007228477	
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	8003545112	WAS GALLAGER & BASSETT SERVICES
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	8889628437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	8003376288	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	8007414810	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	8886716771	
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	7043555200	
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	8886425040	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	8008728276	
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	8064732500	
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	8037868466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
923	UNITED HEALTHCARE COMMUNITY PLAN	PO BOX 6170	COLUMBIA	SC	292606170	8008682528	MEDICAID MCO PLAN
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	124025230	8002246602	
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	8005932080	
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	8002371900	
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	8004267234	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	3178942000	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	8006699030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE.	ALTOONA	PA	166014899		CODE ASSIGNED BY SCHA
934	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 3252	MILWAUKEE	WI	53201	8668676883	
937	MVP HEALTH CARE	PO BOX 2207	SCHENECTADY	NY	12301	8002295851	NAME CHANGE ONLY 4/09. WAS PREFERRED CARE
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	8032968999	CODE ASSIGNED BY SCHA
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 6090	DEPERE	WI	54115	6087793000	CODE ASSIGNED BY SCHA 6/18/07
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST.	MIDDLETOWN	NY	10940	8008267531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	8002474695	
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR.	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	8008100906	DORMANT 8/06
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	8668478235	
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	8005527879	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NE	89109	8008424742	
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	8004564002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST., STE. 201	PHOENIX	AZ	85020	8008723860	CODE ASSIGNED BY SCHA
954	MULTIPLAN	115 5TH AVE.	NEW YORK	NY	100031004	8005463887	
955	DESIGN SAVERS PLAN	2814 SPRING RD., STE. 122	ATLANTA	GA	30339	8006165709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
960	HEALTH EOS	PO BOX 6090	DER PERE	WI	541156090	8004355694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	8004584642	CODE ASSIGNED BY SCHA
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	8779344403	
963	UNITED HEALTHCARE CLAIMS	PO BOX 29130	HOT SPRINGS	AR	71903	8882014111	
964	PHARMACEUTICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	8007770074	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	6306553755	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 188061	CHATTANOOGA	TN	37422	8886506566	
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	8006781536	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	6304161111	
969	WHP HEALTH INITIATIVE	PO BOX 968022	SCHAUMBERG	IL	601968022	8002072568	
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	8009195514	CODE ASSIGNED BY SCHA
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	8005481256	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49516	8009682449	
973	CAMBRIDGE INTEGRATED SERVICES GROUP, INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	8007669780	USE CARRIER 171 AON
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	8002239941	
975	INFORMED RX	PO BOX 968022	SCHAUMBURG	IL	601968022	8006453332	WAS NATIONAL MEDICAL HEALTH CARD
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	7062776710	
977	ZENITH ADMINISTRATION	26359	LAS VEGAS	NV	89126	8004265980	DORMANT 8/06
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	8773112150	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	6159633826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINESVILLE	GA	30503	8007774782	
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	8005227487	
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	8002728451	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE.	PHOENIX	AZ	85040	6022340497	
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	8004934240	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	8003621116	
986	COMMONWEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	8005261677	
987	BANKERS FIDELITY LIFE INS CO	PO BOX 105652	ATLANTA	GA	30348	4042665500	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	8007331110	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	8772429464	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON-SALEM	NC	27101	8003348159	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	8883065299	
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	8003210935	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	2488539010	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	8005198374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
995	MEDIMPACT	10680 TREENA ST., STOP 5	SAN DIEGO	CA	92131	8007882949	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	8003313287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	8778259337	CODE IN OPEN STATUS BY SCHA
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD., STE. 100	ATLANTA	GA	30348	8003332542	
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	8007203150	BOUGHT BY CIGNA HEALTHCARE CC 134
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	8004517715	
100RX	AETNA PHARMACY	PO BOX 52444	PHOENIX	AZ	850722444	8002386279	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	8008415550	USE CODE 280 CAREMARK
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	8005215505	
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	8002446224	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188053	CHATTANOOGA	TN	374228053	8006225579	USE CARRIER CODE 718

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
139DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	84130	8008269781	WAS WAUSAU INS. CO.
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU	WI	544028013	8008269781	
143DN	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 659444	SAN ANTONIO	TX	75265	8772179677	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
206DN	MED COST BENEFITS SERVICES	PO BOX 25987	WINSTON-SALEM	NC	27114	8007951023	
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 981572	EL PASO	TX	799981572	8005417846	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	8005544954	
300DN	BENEFIT ADMINISTRATORS, INC.	PO BOX 6279	ERIE	PA	16512	8007772524	
302DN	GOVERNMENT EMPLOYEE HOSP. ASSOC. (GEHA)	PO BOX 21542	EAGAN	MN	55121	8774342336	DENTAL COVERAGE
308DN	GREAT WEST LIFE	PO BOX 188037	CHATTANOOGA	TN	37422	8776314227	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
315DN	THOMAS COOPER AND COMPANY	PO BOX 63477	NORTH CHARLESTON	SC	29419	8437222115	
321DN	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 1358	GLEN BURNIE	MD	21060	8002222798	
345DN	EMPLOYEE BENEFIT SERVICES, INC.	PO BOX 1929	FORT MILL	SC	29716	8002421510	
370DN	DELTAHEALTH SYSTEMS	PO BOX 702500	WEST VALLEY	UT	84170	8774740605	
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	527332940	8004427742	DHHS INTERNAL RECOVERY CLAIMS BILLING MUST BE FAX TO: 414-224-0472
387DN	HEALTHGRAM	PO BOX 11088	CHARLOTTE	NC	28220	8004465439	DENTAL - HEALTHGRAM FORMERLY PRIMARY PHYSICIANS CARE
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8037883860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
445DN	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO.	PO BOX 6018	CLEVELAND	OH	441011018	800315 314	DENTAL ONLY
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DES PLAINES	IL	60017	8003235000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
552DN	CORESOURCE, INC.	PO BOX 2920	CLINTON	IA	52733	8003275462	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 99005	LUBBOCK	TX	79490	8009676831	
709DN	MARSH ADVANTAGEAMERICA	501 NORTH BROADWAY, STE. 500	ST. LOUIS	MO	63102	8008687526	FORMERLY BENEFIT PLAN SERVICES
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
836DN	HUMANA	PO BOX 14601	LEXINGTON	KY	40512	8005584444	
842DN	GARDNER AND WHITE, INC.	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
857DN	CORPORATE BENEFIT SERVICES, INC.	PO BOX 12954	CHARLOTTE	NC	28220	7043730447	
879DN	DENEX DENTAL	111 ROCKVILLE PIKE STE. 700	ROCKVILLE	MD	20850	8666904908	DENEX DENTAL IS A PLAN UNDER WELLPATH SELECT/COVENTRY
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
886DN	PLANNED ADMINISTRATORS, INC.	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
889DN	GROUP INSURANCE ADMINISTRATION, INC.	3350 PEACHTREE RD. NE STE. 1040	ATLANTA	GA	30326	8006210683	
897DN	SOUTHERN BENEFITS ADMINISTRATORS DENTAL	5305 VIRGINIA BEACH BLVD.	NORFOLK	VA	23502	7574618091	
909DN	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	2059691155	
937DN	MVP HEALTH CARE	PO BOX 763	SCHENECTADY	NY	12301	8004805640	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD.	APPLETON	WI	54919	8008474836	
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD., STE. 106	ATLANTA	GA	30341	8002417319	
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	8005221246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50 EMPLOYEES. SEE CC212 FOR GROUPS OVER 50 EMPLOYEES.
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD., STE. 700	ATLANTA	GA	303501853	8003654944	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	8002568606	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	8005234000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	8037824947	
A08	INDEPENDENCE AMERICAN INS. CO. (IHC HEALTH SOLUTION)	PO BOX 21456	EAGON	MN	55121	8664290608	
A09	RX AMERICA	221 N CHARLES LINDBERG DR.	SALT LAKE CITY	UT	84116	8007708014	
A10	AMERISCRIPT	4301 DARROW RD., STE. 4200	STOW	OH	44224	8006816912	
A11	PREFERRED ADMINISTRATORS	15560 NORTH FLW BLVD.	SCOTTSDALE	AZ	85260	8772767198	
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	8669527979	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	8004043344	
A14	EB RX	2045 MIDWAY DR.	TWINSBURG	OH	44087	8008007153	
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST. LOUIS	MO	631016922	8007596959	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD., STE. 300	SAN ANTONIO	TX	782181610	8008999355	
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD.	GRAND ISLAND	NY	140720308	8003333195	
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	8888421530	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC.`	3 TOILSOME LANE	EAST HAMPTON	NY	11937	8009262306	CODE ASSIGNED BY SCHA
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A21	PC HEALTH PLAN ADMINISTRATION	PO BOX 1377	THOMASVILLE	GA	31799	8884261937	CODE ASSIGNED BY SCHA
A22	PIEDMONT ADMINISTRATORS	PO BOX 25307	WINSTON-SALEM	NC	271145307	8008527040	
A23	SERV U PRESCRIPTION	PO BOX 26096-0096	MILWAUKEE	WI	53226	8007593203	
A24	WELLPOINT NEXT RX	PO BOX 2902	CLINTON	IA	527332902	8009627378	USE CARRIER 333 EXPRESS SCRIPTS
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE.	GREENWOOD VILLAGE	CO	80111	8003453189	
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	8002792290	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	8005544022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	8008485433	
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	8006064841	
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	8003623308	
A32	MAGELLAN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	8003592422	
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	8002834927	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	8003683429	DORMANT 8/06
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	8642991720	CODE IN OPEN STATUS BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	8002223693	
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	8005575745	
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	8009991147	
A39	COMPLETE BENEFITS SOLUTIONS	6071 CARMEL RD., STE 305	CHARLOTTE	NC	28226	8662702316	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	8887729682	
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREEN BAY	WI	54307	8004727130	
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	4043811000	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE.	PENSAUKEN	NJ	08109		CODE ASSIGNED BY SCHA
A44	GLOBAL MEDICAL MANAGEMENT, INC.	7901 SW 36TH ST., STE. 100	DAVIE	FL	33328	9543706404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR., STE. 400	DALLAS	TX	75231	8009593953	
A46	STANDARD INSURANCE COMPANY	PO BOX 82622	LINCOLN	NE	68501	5033217000	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	7135266000	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	8005685628	DORMANT 8/06
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHOENIX	AZ	850622909	6022318855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A52	NATIONWIDE SPECIALTY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	8005174791	
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	8884441995	NEIC 30018
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	8004233289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	8642772371	DORMANT 8/06
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR., STE. 200	LAS VEGAS	NV	89109	8008424742	CODE ASSIGNED BY SCHA
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	8008283605	
A60							
A61	SUMMACARE HEALTH PLAN	PO BOX 3620	AKRON	OH	743893628	8009968701	
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	8882641512	
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	8643340090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	8282819000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A65	DATARX	5920 ODELLE ST.	CUMMINGS	GA	30040	8778231273	
A66	PRAIRIE STATES ENTERPRISES, INC.	PO BOX 23	SHEBOYGAN	WI	530820023	8008157020	
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	8009676831	
A68	HOLLINGSWORTH SACO LOWELL CORP.	PO DRAWER 2327	GREENVILLE	SC	29602	8648593211	DORMANT 8/06
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	8003310420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	8008225899	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON-SALEM	NC	271571137	8004757900	
A72	BABB, INC.	850 RIDGE AVE.	PITTSBURGH	PA	15212	8002456102	
A73	CLAIMS TECHNOLOGY, INC.	100 COURT AVE., STE. 306	DES MOINES	IA	50309	8002458813	
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	8008113298	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	8882295020	WAS LIFECARE CENTERS OF AMERICA
A76	TOWER LIFE INS. CO.	310 S. MARY ST.	SAN ANTONIO	TX	78205	8006606077	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	8004574725	
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	8883502002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	9724926474	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	8007522211	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	3372341789	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A83	GROUP RESOURCES, INC.	PO BOX 100043	DULUTH	GA	300969343	7706238383	
A84	HCC LIFE INSURANCE COMPANY	PO BOX 2005	FARMINGTON HILLS	MI	48333	8664004102	
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	8002357111	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	8002629175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	8005738597	
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	8888588551	
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	8007676811	CODE ASSIGNED BY SCHA
A90	EMPLOYEE BENEFIT CLAIMS, INC.	9501 WEST DEVON	ROSEMONT	IL	60018	3126963660	
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST., STE. 1200	FORT WORTH	TX	761027012	8007828375	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	8007535133	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	8004331672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	8774925870	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	8007363539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A96	HAMRICKS, INC.	742 PEACHOID RD.	GAFFNEY	SC	29340	8644877505	
A98	MERITAIN HEALTH	PO BOX 853921	RICHARDSON	TX	75085	8007654224	
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	8002010450	
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	8889222313	
B01DN	HEALTH PARTNERS DENTAL	PO BOX 1172	MINNEAPOLIS	MN	55440	8889222313	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	8002262371	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	8887563534	
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	8002840042	CODE IN OPEN STATUS BY SCHA
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD.	FRANKLIN	TN	37067	6157784000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE. 1400	ATLANTA	GA	30339	8004702004	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	8666246259	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	39236	8888882519	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	8003484512	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	4046592100	CODE IN OPEN STATUS BY SCHA
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1339	MINNEAPOLIS	MN	55440	8008243882	
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY ST.	BOSTON	MA	02116	8003777311	
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	8007582851	
B13DN	WEB TPA	PO BOX 99906	GRAPEVINE	TX	76099	8007582851	
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	271022000	3367592013	DENTAL ONLY
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	8007439264	
B16	MAGELLAN RX	11013 W BROAD ST., STE. 500	GLEN ALLEN	VA	23060	8006594112	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	8668587223	
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	8774957223	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	8883589484	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	8009909058	
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	8004234586	
B22	COVENTRY HEALTHCARE OF VIRGINIA	PO BOX 7704	LONDON	KY	40742	8006274872	
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	8004232765	
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	2125014444	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	4047555665	
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	8009442833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	8642893000	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	8005479515	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 981644	EL PASO	TX	799981644	8006949888	WAS US NOW INSURANCE GROUP
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	8008314914	
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	8008802745	
B32	MAXCARE	PO BOX 16430	OKLAHOMA CITY	OK	73113	8002597765	
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD., BLDG. 400, UNIT 100	WOODSTOCK	GA	30188	8009333734	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	4046592100	
B35	PROCARE RX PBM	1267 PROFESSIONAL PARKWAY	GAINESVILLE	GA	30507	8006993542	
B36	COMMONWEALTH INDEMNITY PLAN	PO BOX 9016	ANDOVER	MA	01810	8004429033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	8778400936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	8003258424	
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	8006868425	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST.	INDIANAPOLIS	IN	462781758	3173298222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	8003760110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	8668089399	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	8002368672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	8662475678	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	8006334226	
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	8005989799	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	8883282287	
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	8003760110	
B47	PHARMACY DATA MANAGEMENT, INC.	1170 E WESTERN RESERVE RD.	POLAND	OH	44514	8007740890	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	8005385038	
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	8008685200	
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	8888685854	
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	8775592955	
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	2818291033	
B53	NATIONAL FOUNDATION LIFE INSURANCE COMPANY	110 WEST 7TH ST., STE. 300	FORT WORTH	TX	76102	8002219039	
B54	NGS AMERICAN, INC.	PO BOX 2310	MT. CLEMENS	MI	48046	8107797676	
B55	US SCRIPTS	2425 WEST SHAW AVE.	FRESNO	CA	93711	8004608988	
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD.	LAKELAND	FL	33805	8002263155	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	8004579611	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	8004528633	
B59	CASTIARX	701 EMERSON RD., STE. 301	CREVE COEUR	MO	63141	8665163121	
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	8003233359	CODE IN OPEN STATUS BY SCHA
B61	AMERICAN BEHAVIORAL	3680 GRANDVIEW PARKWAY STE. 100	BIRMINGHAM	AL	35243	8009258327	
B62	LIBERTY DENTAL	PO BOX 26110	SANTA ANNA	CA	92799	8889020349	
B63	EASTERN LIFE AND HEALTH INSURANCE	PO BOX 10188	LANCASTER	PA	17605	8002330307	
B64	UNITED MEDICAL RESOURCES, INC.	PO BOX 30541	SALT LAKE CITY	UT	84130	5136193000	
B65	COMPASS ROSE HEALTH PLAN	PO BOX 141501	NASHVILLE	TN	37214	8775311159	
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	8002472192	USE CODE 759 MEDIPLUS PER SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B67	NAVITUS HEALTH SOLUTIONS LLC	PO BOX 999	APPLETON	WI	549120999	8662682501	
B68	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	8009221245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
B70	DECARE DENTAL	PO BOX 1348	MINNEAPOLIS	MN	55440	8005876857	
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	8888031780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	5024261843	CODE ASSIGNED BY SCHA
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	2133856161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	8002881474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	8008930777	
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE. NORTH WEST	WASHINGTON	DC	20006	8002751171	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	8005627079	USE CODE 985 BENESIGHT
B78	ARM GROUP (OMNICARE)	340 QUADRANGLE DR.	BOLINGBROOK	IL	60440	8009687222	
B79	FOX-EVERETT, INC.	PO BOX 6012	RIDGELAND	MI	39158	8774766327	
B80	INTEGRATED BEHAVIORAL HEALTH/IBH	PO BOX 30018	LAGUNA NIGUEL	CA	92607	8003951616	
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	8002792624	
B82	AVANTE HEALTH	1111 E. HERNDON AVE., STE. 308	FRESNO	CA	93720	8664163617	
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	8002728451	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013		CODE IN OPEN STATUS BY SCHA
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	8004238080	
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	8009971750	
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	8003227451	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	8004974474	
B89	RXEDO	7800 DALLAS PARKWAY STE 460	PLANO	TX	75024	8888797336	
B90	FIRST CHOICE VIP CARE	PO BOX 307	LINTHICUM	MD	210900307	8005750418	THIS IS A MEDICARE ADVANTAGE PLAN.
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	8008070400	
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	8004880134	
B93	UNIVERSITY HEALTH ALLIANCE	700 BISHOP ST., STE. 300	HONOLULU	HI	968134100	8005324000	
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	8884113888	
B95	SINCLAIR HEALTH SERVICES	PO BOX 30827	SALT LAKE CITY	UT	84130	8888002230	
B96	ALTERNATIVE RISK MANAGEMENTS (ARM LTD)	814 N.W. HIGHWAY	ARLINGTON HEIGHTS	IL	60004	8003921770	
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	8003741835	
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	8005381053	
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	8662063224	
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	8037721783	CODE ASSIGNED BY SCHA
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG. 3 #400	AUSTIN	TX	78730	8883687910	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	8009695238	
C04	CBA BLUE	PO BOX 9350	SOUTH BURLINGTON	VT	05407	8882229206	DENTAL ONLY
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	8007771647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	8007867930	
C08	BENECARD	PO BOX 2187	CLIFTON	NJ	07015	8007379528	
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	8156335800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	8008417735	WAS PARADIGM CARE PLAN
C11	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281803	
C11DN	MAESTRO HEALTH	P O BOX 1178	MATTHEWS	NC	28106	8002281813	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C12	BENEFIT MANAGEMENT, INC.	PO BOX 1090	GREAT BEND	KS	66210	8002901368	
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	8003213997	
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	8435382876	CODE IN OPEN STATUS BY SCHA
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	4803914600	SEE CARRIER 471
C16	CONSOLIDATED BENEFITS, INC.	PO BOX 23686	COLUMBIA	SC	29224	8037365088	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	2154430404	
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY	FL	34656	8008814474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	8883525246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	8007774013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	6178287000	
C23							
C24	ENCOMPASS HEALTH MANAGEMENT SYSTEM	6000 WEST TOWN PARKWAY STE 350	DES MOINES	IA	50266	8005113389	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST., STE. 2A	RAVENSWOOD	WV	26164	8882250522	
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 1349	WAKE FOREST	NC	27588	8004268739	
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 3245	MILWAUKEE	WI	53201	8004973699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	8776427500	
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	8002519665	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	8006533626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	8645739541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C32	WELL FARGO INSURANCE	PO BOX 91608	LUBBOCK	TX	79490	8004354351	
C32DN	ASSURANT HEALTH	PO BOX 91608	LUBBOCK	TX	79490	8004354351	FORMALLY WELLS FARGO
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	8668269345	
C34	GEOBLUE	933 FIRST AVENUE	KING OF PRUSSIA	PA	19406	8552823517	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	8002286080	SEE CODE C99
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	6086621232	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	8002725466	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	8883501488	
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	4023973200	
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	8883222115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C41	INTERNATIONAL BENEFITS ADMINISTRATORS, INC.	PO BOX 9306	GARDEN CITY	NY	11530	8004227617	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
C42	STANDARD CORPORATION	1400 MAIN ST., STE. 1300	COLUMBIA	SC	29201	8037716785	
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8642356474	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 6927	COLUMBIA	SC	29260	8037986207	
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	8774534201	
C46	MEDCO HEALTH SOLUTIONS	PO BOX 2902	CLINTON	IA	527332902	8002727243	USE CARRIER 333 EXPRESS SCRIPTS
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	8004268803	
C49	ACS CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008495370	WAS PENN WESTERN
C49DN	PENN WESTERN BENEFITS, INC.	PO BOX 2000	WINSTON-SALEM	NC	27102	8008465370	
C50	TENNESSEE BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C51	YALEHEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	2034320250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE. 201	LILBURN	GA	30047	7704517550	
C53							
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW, STE. 500	WASHINGTON	DC	20005	2023936600	
C56	COMPDENT	1930 BISHOP LANE STE. 132	LOUISVILLE	KY	40218	8006331262	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	8004564553	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C59	HUMANA CHOICE (PPO)	PO BOX 14605	LEXINGTON	KY	405784602	8004574708	MEDICARE ADVANTAGE PLAN
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICARE ADVANTAGE (PPO)
C65	PRESBYTERIAN HEALTHCARE SERVICES	PO BOX 27489	ALBUQUERQUE	NM	87125	8003562219	
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	3094942363	
C67					-----		
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	8004459090	
C69							
C70	AMERICAN RETIREMENT LIFE	PO BOX 30010	AUSTIN	TX	757553010	8664591755	REQUESTED BY THE SCHA
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	8002612393	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR., STE. 2000	LITTLE ROCK	AR	72211	8882424800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	8005470421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	7043643865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	7043643865	
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	8002263155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C76	WESTERN AND SOUTHERN GROUPS	PO BOX 5735	CINCINNATI	OH	45201	8004248622	
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE.	CLEVELAND	OH	44114	8004213959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C78	KAISER PERMANENTE	PO BOX 370010	DENVER	CO	80237	4042612590	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR., STE. 1B	HOMEWOOD	IL	60430	7087997400	
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	8887768851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD.	ROCKVILLE	MD	20850	8002474144	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	PO DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	4052334000	CODE IN OPEN STATUS BY SCHA
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 1468	ARLINGTON	TX	76004	8669734647	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	7135290045	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	8006336752	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST. LOUIS	MO	63141	3148780101	
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	8008732022	
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	8006380589	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	8004761555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C92	AMERICAN HEALTH CARE	3850 ATHERTON RD.	ROCKLIN	CA	95765	8008728276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST.	ROSEVILLE	CA	95661	8008728276	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	8003282739	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C95	MIDWEST SECURITY	2700 MIDWEST DR.	ONALASKA	WI	54650	8002368672	
C96	MEDTRACK SERVICES	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	8002428923	
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	PO BOX 950	FORREST HILL	MA	60631	8885323467	
C99	MEDICO INSURANCE COMPANY	PO BOX 21660	EAGAN	MN	55121	8002286080	CARRIER WAS PREVIOUSLY C35.
CAS	CASUALTY CASE						
CO5							
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	8177617611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT. #205	HILLSBORO	OR	97124	5036402000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	8009896739	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	8006246052	
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	8008158240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	MEDICARE ADVANTAGE PLAN
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	3237227171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	8772542363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD.	JACKSONVILLE	FL	32256	8008920059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D10	SEVEN CORNERS, INC.	PO BOX 3430	CARMEL	IN	46082	8666994186	
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	8884191094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	8882024340	MEDICARE ADVANTAGE PLAN
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	8007756490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD.	SOUTHFIELD	MI	48034	8002495103	MEDICARE ADVANTAGE PLAN
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	8884458916	MEDICARE ADVANTAGE PLAN
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	8006240756	MEDICARE ADVANTAGE PLAN
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	8662352770	MEDICARE ADVANTAGE PLAN
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	8006428065	MEDICARE ADVANTAGE PLAN
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	8882601010	MEDICARE ADVANTAGE PLAN
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	8778839577	MEDICARE ADVANTAGE PLAN
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	8656707790	MEDICARE ADVANTAGE PLAN
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	8668659329	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	8003089823	MEDICARE ADVANTAGE PLAN
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	8002403870	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	7189218818	MEDICARE ADVANTAGE
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	8002341228	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	7148253828	MEDICARE ADVANTAGE PLAN
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	4076281776	MEDICARE ADVANTAGE PLAN
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR., STE. 3900	CHICAGO	IL	68606	3123247000	MEDICARE ADVANTAGE PLAN
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	8607025000	MEDICARE ADVANTAGE PLAN
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	3055595366	MEDICARE ADVANTAGE PLAN
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	8778423210	MEDICARE ADVANTAGE PLAN
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	8007135095	MEDICARE ADVANTAGE PLAN
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST. PETERSBURG	FL	33731	8666904842	MEDICARE ADVANTAGE PLAN
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	8007737725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST., STE. 200	PITTSBURGH	PA	15203	8448517293	DENTAL ONLY
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	8009221245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D39	NEW YORK WELFARE FUND	101-49 WOODHAVEN BLVD.	OZONE PARK	NY	11416	7188455800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST.	DULUTH	MN	55802	8888128800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	8007872680	
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	8666862506	MEDICARE ADVANTAGE PLAN
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8666178585	MEDICARE ADVANTAGE PLAN
D45	HIGHMARK SECURITY BLUE	120 5TH AVE.	PITTSBURGH	PA	15222309	8005473627	MEDICARE ADVANTAGE PLAN
D46	GROUPHEALTH OPTIONS, INC.	PO BOX 34585	SEATTLE	WA	98124	8887674670	MEDICARE ADVANTAGE PLAN
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	8887770204	MEDICARE ADVANTAGE PLAN
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	6153371300	MEDICARE ADVANTAGE PLAN
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	8662311821	MEDICARE ADVANTAGE PLAN
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	8882742207	MEDICARE ADVANTAGE PLAN
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	8006855209	MEDICARE ADVANTAGE PLAN
D55	TOTAL CAROLINA CARE, INC.	1441 MAIN ST.	COLUMBIA	SC	29210	8664336031	MEDICAID HMO
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	8667691157	MEDICARE ADVANTAGE PLAN
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	8005779410	MEDICARE ADVANTAGE PLAN
D58	BRAVO HEALTH MEDICARE ADVANTAGE	PO BOX 4433	BALTIMORE	MD	21223	8005561570	MEDICARE ADVANTAGE PLAN
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	8006004441	CODE ASSIGNED BY SCHA
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	8663213947	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	8665798774	MEDICARE ADVANTAGE PLAN
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	8006171114	MEDICARE ADVANTAGE PLAN
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	8037888562	MEDICARE ADVANTAGE PLAN
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	8882909160	MEDICARE ADVANTAGE PLAN
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	MEDICAID HMO

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	8773522583	MEDICARE ADVANTAGE PLAN
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	8007437141	MEDICARE ADVANTAGE PLAN
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	8002273116	MEDICARE ADVANTAGE PLAN
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	8002480457	
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANO	TX	750269025	8662705223	MEDICARE ADVANTAGE PLAN
D79	EMPLOYEE HEALTH INSURANCE MANAGEMENT (EHIM)	26711 NORTHWESTERN HWY STE. 400	SOUTHFIELD	MI	48033	8003113446	
D81	HEARTLAND NATIONAL LIFE INSURANCE CO.	PO BOX 2878	SALT LAKE CITY	UT	84110	8008723860	REQUESTED BY THE SCHA
D82	SOLSTICE	PO BOX 14009	LEXINGTON	KY	40512	8777602247	
D85	US FIRE INSURANCE COMPANY	3195 LINWOOD RD., STE. 201	CINCINNATI	OH	45208	8005132981	
D87	LIFESTYLE HEALTHCARE	345 N. RIVERVIEW STE. 600	WICHITA	KS	67203	8668276607	FORMERLY MEDOVA HEALTHCARE
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D99	MEDICARE ADVANTAGE						MEDICARE ADVANTAGE PLAN GENERIC CODE
E102	PROTECTIVE LIFE INSURANCE	PO BOX 12687	BIRMINGHAM	AL	35202	2052687055	CANCER POLICY ONLY
E12	CAROLINA CRESCENT	1201 MAIN ST., STE. 970	COLUMBIA	SC	29201	8032516630	HEALTHY KIDS CONNECTION
E20	VRX PHARMACY SERVICES	PO BOX 9780	SALT LAKE CITY	UT	84109	8778799722	
E23	MAINE SENSE	PO BOX 1959	GRAY	ME	04039	8002908559	
E24	PBM PLUS	300 TECHNECENTER DR., STE. C	MILFORD	OH	45150	8002632178	
E29	BEST LIFE AND HEALTH INSURANCE CO.	PO BOX 890	MERIDIAN	ID	836800890	8004330088	
E30	BUSINESS ADMINISTRATORS AND CONSULTANTS, INC.	PO BOX 107	REYNOLDSBURG	OH	43068	8005212654	
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	8882762020	HEALTHY KIDS CONNECTION
E38	UNISON HEALTH PLAN	250 BERRYHILL RD.	COLUMBIA	SC	29210	8037985852	HEALTHY KIDS CONNECTION
E41	MEDTRAK	7101 COLLEGE BLVD., STE. 1000	OVERLAND PARK	KS	66210	8007714648	
E42	TRUE RX	4 WILLIAMS BROTHERS DR.	WASHINGTON	IN	47501	8669214047	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
E43	THE HEALTH PLAN INSURANCE CO.	52160 NATIONAL RD. EAST	ST. CLAIRSVILLE	OH	43950	7406996273	
E44	ALTERNATIVE INSURANCE RESOURCE, INC.	PO BOX 680787	BIRMINGHAM	AL	352660787	8004514318	
E45	UNIFIED LIFE INSURANCE	PO BOX 25326	OVERLAND	KS	662255326	9136852233	
E46	TOLEDO FIREFIGHTERS HEALTH PLAN	PO BOX 5810	TROY	MI	480075810	4192555314	
E51	CHOICE BENEFITS	3801 OLD GREENWOOD RD.	FT. SMITH	AR	75278	8004516907	
E54	ALLEGIANCE BENEFIT PLAN MANAGEMENT	PO BOX 3018	MISSOULA	MT	598063018	8008771122	
E55	AG ADMINISTRATORS	PO BOX 979	VALLEY FORGE	PA	19482	8006348628	
E61	HEALTHEZ	PO BOX 398220	MINNEAPOLIS	MN	55439	8552809638	
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR.	COLUMBIA	SC	29210	8668022474	
E73	TRISTAR BENEFIT ADMINISTRATORS	PO BOX 65887	WEST DES MOINES	IA	50265	8004564584	
E80	KANSAS INDEPENDENT PHARMACY (KPSC)	4125 SOUTH WEST GAGE CENTER DR., STE. 203	TOPEKA	KS	66604	8002793022	
E81	SELECT ADMINISTRATIVE SERVICES (SAS)	PO BOX 3209	GULFPORT	MS	39503	8008476621	
E82	SIMPLE BENEFIT PLANS	2810 PREMIER PARKWAY STE. 400	DULUTH	GA	30097	8002704158	
E87	BENEFIT ADMINISTRATIVE SYSTEMS	PO BOX 2920	MILWAUKEE	WI	53201	8005250582	
E89	BROADREACH MEDICAL RESOURCES	1350 BROADWAY #410	NEW YORK	NY	10018	8887182375	
E90	UNITED HEALTH (MEDICARE SOLUTIONS)	PO BOX 30436	SALT LAKE CITY	UT	84130	8778423210	MEDICARE ADVANTAGE
E91	SCOTT AND WHITE HEALTH PLAN	PO BOX 21800	EAGAN	MN	55121	8003217947	
E93	CUSTOM DESIGN BENEFITS	5589 CHEVIOT RD.	CINCINNATI	OH	45247	8005982929	
E95	TRUESCRIPTS	PO BOX 921	WASHINGTON	IN	47501	8442571955	RX
E96	MEDPARTNERS ADMINISTRATIVE	6920 POINT INVERNESS WAY	FORT WAYNE	IN	46804	8883129744	
E97	SIGNATURE CARE	PO BOX 5548	FORT WAYNE	IN	46895	8006664449	
E99	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	
E99RX	MAXORPLUS	320 SOUTH POLK ST., STE. 200	AMARILLO	TX	79101	8006870707	RX ONLY
F11	SOUTHERN SCRIPTS	PO BOX 2482	NATCHIPOCHES	LA	71457	8007109341	RX
F13	DENTEGRA	PO BOX 1850	ALPHARETTA	GA	300231850	8772804202	DENTAL
F14	MERIDIANRX	PO BOX 9306	GARDEN CITY	NY	48226	8553234580	RX

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
F18	CARE CONNECT	PO BOX 830259	BIRMINGHAM	AL	352830259	8557067545	
F19	LIFEMAP	PO BOX 783	MILWAUKEE	WI	53201	8002841129	
F20	HEALTHPLEX	PO BOX 9255	UNIONDALE	NY	11553	8004680600	DENTAL
F21	TRUSTEED PLAN SERVICE	PO BOX 2950	TACOMA	WA	98401	2535645611	
F22	CONSOLIDATED HEALTH PLANS	2077 ROOSEVELT AVE.	SPRINGFIELD	MA	01104	8006337867	DENTAL
F23	WELLDYNE RX	PO BOX 90369	LAKELAND	FL	33804	8884792000	
F25	FIDELIO DENTAL INSURANCE COMPANY	2826 MT. CARMEL AV.	GLENSIDE	PA	19038	8002624949	DENTAL
F27	3PADMINISTRATORS	PO BOX 247	ONALASKA	WI	54650	6087793000	DENTAL ONLY
F28	CONTINENTAL BENEFITS	PO BOX 3610	BRANDON	FL	335093610	8553030837	
F29	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	
F29DN	BENEFIT COORDINATORS	PO BOX 210546	COLUMBIA	SC	29221	8037220110	DENTAL
F31	WILLIAM C. EARHART CO., INC.	PO BOX 97208	PORTLAND	OR	97208	8008460611	
F31DN	WILLIAM C. EARHART CO., INC.	PO BOX 4148	PORTLAND	OR	97208	8008460611	DENTAL ONLY
F32	DENTAL SELECT	PO BOX 851917	RICHARDSON	TX	75085	8014953000	DENTAL
F37	DISTRICT COUNCIL #37	125 BARCLAY ST.	NEW YORK	NY	10007	2158151600	DENTAL ONLY
F40	CITIZEN'S RX	1144 LAKE ST.	OAK PARK	IL	60301	8775327912	RX ONLY
F41	HEALTHCARE HIGHWAYS RX	5904 STONE CREEK DR.	THE COLONY	TX	75056	8446367506	RX ONLY
F42	PROACT	1126 US HIGHWAY 11	GOUVERNEUR	NY	13642	8662869885	RX ONLY
F43	TRICARE EAST	PO BOX 7981	MADISON	WI	537077981	8004445445	
F45	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	
F45DN	LIFETIME BENEFIT SOLUTIONS	PO BOX 780	LIVERPOOL	NY	13088	8772543132	DENTAL ONLY
F46	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	
F46DN	HEALTH RESOURCES, INC.	PO BOX 659	EVANSVILLE	IN	47704	8007271444	DENTAL ONLY
F49	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	
F49DN	BLUE CROSS BLUE SHIELD OF WYOMING	PO BOX 2266	CHEYENNE	WY	82003	8004422376	DENTAL ONLY
F50	FRINGE BENEFIT GROUP	PO BOX 21854	EAGAN	MN	55121	8772201862	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS OFFICE
F51	INSURANCE TPA	PO BOX 15953	LUBBOCK	TX	79490	8558489591	ASSIGNED BY SC REVENUE AND FISCAL AFFAIRS
F53	BOON GROUP	PO BOX 559017	AUSTIN	TX	78755	8664750056	ADDED BY SC REVENUE AND FISCAL AFFAIRS

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
F54	ALLEGIANCE	PO BOX 3018	MISSOULA	MT	59806	8559992271	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F55	COMMONWEALTH CARE ALLIANCE	PO BOX 2280	PORTSMOUTH	NH	14315	8666102273	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F56	CAREFIRST BLUECHOICE MARYLAND	PO BOX 14116	LEXINGTON	KY	40512	8008425975	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F57	AMBETTER PEACH STATE HEALTH PLAN	PO BOX 5010	FARMINGTON	MD	636405010	8776871180	ADDED BY SC REVENUE AND FISCAL AFFAIRS
F58	KAISER PERMANENTE MID ATLANTIC STATES	PO BOX 371860	DENVER	CO	802379998	8008104766	ADDED BY REVENUE AND FISCAL AFFAIRS
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	40512	8005244555	
X0A	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF OF GA.
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS, INC.	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA, INC.	PO BOX 9907	COLUMBUS	GA	319086007	4048428000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 659444	SAN ANTONIO	TX	78265	4048428000	
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	8002144844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON-SALEM	NC	271022100	9194897431	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	8007272227	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	8003429816	
X0EDN	EMPIRE BCBS DENTAL	PO BOX 791	MINNEAPOLIS	MN	554400791	8007228879	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	8009916061	
X0G							
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	4142246100	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	8005244555	USE CARRIER X01
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	8006373493	
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	5032255221	
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	8884371508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE, INC.	PO BOX 1991	WILMINGTON	DE	19899	3024210260	
X0M	BLUE CROSS OF MASSACHUSETTS, INC.	PO BOX 986020	BOSTON	MA	022986020	8002535210	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	8002535210	DENTAL ONLY
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	8004510287	
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	8004947218	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35201	8005176425	DO NOT USE FOR MEDICARE. THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 830389	BIRMINGHAM	AL	352830389	8005176425	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	8004689736	
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	8005659140	
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 312500	DETROIT	MI	48231	8004820898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	8888268152	
X0R	MEDICAL MUTUAL OF OHIO	PO BOX 6018	CLEVELAND	OH	44101	2166877000	
X0RDN	MEDICAL MUTUAL OF OHIO	PO BOX 981800	EL PASO	TX	79998	2166877000	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1219	NEWARK	NJ	07101	8006241110	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1311	MINNEAPOLIS	MN	55440	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	8006348644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	8668260914	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY, INC.	9901 LINN STATION RD.	LOUISVILLE	KY	40223	5024232011	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	5184534600	
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	8006776669	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	6144645870	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	8005529159	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	8006224822	
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	8006224822	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC.	PO BOX 1043	JACKSON	MS	39215	6016644590	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	8007113795	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	2024798000	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	8097599898	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	4018317300	
X1FDN	BLUE CROSS BLUE SHIELD OF RHODE ISLAND	PO BOX 69427	HARRISBURG	PA	171069427	8008312400	DENTAL ONLY
X1G	INDEPENDENCE BLUE CROSS	PO BOX 211184	EAGAN	MN	551212594	8002752583	
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT, INC.	PO BOX 533	NORTH HAVEN	CT	06473	2032394961	
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.	PO BOX 2181	LITTLE ROCK	AR	72203	5013782010	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	8008880757	
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD.	MEMPHIS	TN	38103	9015293111	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	5042915370	
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	7852914180	
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	5095364900	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	5152454500	USE CARRIER CODE X2A
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST. PAUL	MN	55164	8003822000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	2077751550	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 890062	CAMPHILL	PA	170890062	4125447000	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	5132821016	CODE IN OPEN STATUS BY SCHA
X1T							
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN PO STATION	OMAHA	NE	681800001	4023901820	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BROADWAY	DENVER	CO	80273	3038312131	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	8013332100	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	8003621279	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	95927	8882351765	
X1YDN	BLUE SHIELD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	8887024171	
X1Z							
X20							
X21							
X25							
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	8005268995	
X2ADN	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 9354	DES MOINES	IA	503069354	8773330164	DENTAL
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	8008926048	
X2C							
X2D							
X2E							
X2F	EXCELLUS BLUECROSS BLUESHIELD	PO BOX 21146	EAGAN	MN	551210146	8007344069	TO VERIFY DENTAL COVERAGE CALL 1-800-724-1675
X2FDN	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	7163253630	DENTAL
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	3154483801	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	3157984238	
X2I							

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	8003682312	
X2K	CAPITAL BLUE CROSS	PO BOX 211457	EAGAN	MN	551213057	8009622242	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	PO BOX 890179	CAMP HILL	PA	170890179	8008298599	
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	8007221471	
X2N							
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA, INC.	PO BOX 1353	CHARLESTON	WV	25325	3043477709	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	3044247700	
X2Q							
X2R							
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 2365	SOUTH BURLINGTON	VT	54072365	054072365	
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	9185603535	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST. LOUIS	MO	63103	3149234444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	2083447411	
X2VDN	BLUE CROSS OF IDAHO HEALTH SERVICE	PO BOX 7408	BOISE	ID	83707	2083447411	DENTAL ONLY
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	8007764672	
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	4067914000	
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	8008808824	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	8885022789	
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY MM PLAN IS X0K
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK, INC.	PO BOX 15013	ALBANY	NY	12212	5184385500	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71093	8007887871	FORMERLY PRESCRIPTION SOLUTIONS

APPENDIX 3 COPAYMENT SCHEDULE

The Copayment schedule reflects amounts the beneficiary is expected to pay to the provider at the time services are received. The current amounts are effective for dates of service on and after July 11, 2011 per Medicaid bulletin dated July 8, 2011, unless otherwise noted.

Service	Procedure Code/ Frequency	Amount
Physician Office Visits (Physician/Nurse Practitioner)	90791-90792 92002-92014 99201-99205 99212-99215 99241-99245	$3.30
*Durable Medical Equipment and Supplies	Services per day	$3.40
Optometrist	92002-92014 99201-99205 99212-99215 99241-99245	$3.30
Chiropractor	98940 98941 98942	$1.15
Podiatrist	99201-99205 99212-99215 99241-99245	$1.15
Home Health	S9128 S9129 S9131 T1021 T1028 T1030 T1031	$3.30
Federally Qualified Health Center (FQHC)	T1015	$3.30
Rural Health Clinic (RHC)	T1015	$3.30
Ambulatory Surgical Center	Services per day	$3.30
Dental	Services per day	$3.40

APPENDIX 3 COPAYMENT SCHEDULE

Service	Procedure Code/ Frequency	Amount
Pharmacy (The prescription copayment will apply to ages 19 and above only.)	Per prescription/refill	$3.40
Note: Effective for dates of service on and after July 1, 2015, the copayment will be $0 for certain medications for the treatment of diabetes, behavioral health disorders and smoking cessation products. Refer to the Pharmacy Co-Payment Waiver Medicaid bulletin dated May 26, 2015.		
Inpatient Hospital	Per admission	$25.00
Outpatient Hospital **(non-emergency)**	Per claim	$3.40

*__Note__: Durable Medical Equipment that is under a rent to purchase payment plan will have the $3.40 copayment split evenly among the 10-month rental payment schedule.

PROVIDER MANUAL SUPPLEMENT

MANAGED CARE

TABLE OF CONTENTS

PROVIDER MANUAL SUPPLEMENT

MANAGED CARE

TABLE OF CONTENTS

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (SCDHHS) to establish a medical home for all Medicaid Managed Care eligible members. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the member's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide members access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide member education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all Managed Care Organizations (MCOs). These additional benefits vary from MCO to MCO according to the contracted terms and conditions between SCDHHS and the managed care entity. Members and providers should contact the MCO with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Waving Co-pays on some services

The Managed Care Division administers the program for Medicaid-eligible members by contracting with Managed Care Organizations (MCOs) to offer health care services. An MCO must receive a Certificate of Authority from the SC Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and the South Carolina Department of Health and Human Services (SCDHHS).

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the Managed Care Policy and Procedure Guide and the Managed Care contract for detailed program-specific requirements. Both the guide and the contract are located on the SCDHHS Web site at www.scdhhs.gov within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs currently participating in the Medicaid Managed Care program as MCOs are subject to change at any time. Providers are encouraged to visit the SCDHHS website (www.scdhhs.gov) for the most current

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

listing of MCOs, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Managed Care Division at the following address:

South Carolina Department of Health and Human Services
Managed Care Division
Post Office Box 8206
Columbia, SC 29202-8206
Phone: (803) 898-4614
Fax: (803) 255-8232

PROGRAM DESCRIPTION

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals. Providers wanting to contract with an MCO must be enrolled in South Carolina Medicaid with SCDHHS.

Primary care providers (PCP) must be accessible within a thirty (30) mile radius, while specialty care providers, to include hospitals, must be accessible within a fifty (50) mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in other counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid as most claims are filed to and processed by the MCO.

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefit package similar to the current FFS Medicaid plan. MCO plans are required to provide members with “medically necessary” care for all contracted services. While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made by the MCO must be approved by SCDHHS. These benefits may include medical services which are currently non-covered by FFS and/or which are above current Medicaid limitations.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov) for a detailed explanation of core benefits.

Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or reimburse certain FFS benefits. Providers rendering services that are not included in the MCO's benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the member's continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the Managed Care Policy and Procedures Guide on the SCDHHS website www.scdhhs.gov.

MCO Program Identification (ID) Card

Managed Care Organizations issue an identification card to beneficiaries within fourteen (14) calendar days of the selection of a primary care provider, or the date of receipt of the member's enrollment data from SCDHHS, whichever is later.

To ensure immediate access to services, the provider should verify eligibility and enrollment through the Medicaid provider web tool regardless of a member's ability to supply a SC Medicaid or MCO ID card. The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the member to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The member's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number
- The MCO and SC Medicaid logos

Claims Filing

Providers should file claims with the MCO for members participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers should contact the MCO for billing and prior authorization requirements prior to rendering services to MCO enrolled members. An exception is services rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning emergency coverage can be found in the MCO contract and Managed Care Policy and Procedure Guide.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Prior Authorizations and Referrals

Providers, both in and out of network, should contact the member's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA.PA requirements may also differ according to the terms of a provider's contract with an MCO.

Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge may also require prior authorization.

Medical Homes Networks (MHNs) - Medically Complex Children's Waiver

SCDHHS administers one MHN specifically for individuals that are enrolled in the Medically Complex Children's Waiver program. Medical Homes Networks (MHNs) are Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers for this specific population. They work in partnership with the member to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for members and managing their care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management.

The outcome of this medical home is a healthier, better educated Medicaid member, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

MHN Program Identification (ID) Card - Medically Complex Children's Waiver

A separate identification card is not issued for members enrolled in this program. Beneficiaries enrolled in this MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility at the Medicaid provider web tool.

Core Benefits - Medically Complex Children's Waiver

Services provided under this MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS Medicaid.

Prior Authorizations and Referrals - Medically Complex Children's Waiver

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the member via a referral. If a member has failed to establish a medical

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a member to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the member was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP's responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the member to a second specialist for the same diagnosis, the beneficiary's PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN's authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the member's eligibility on the date of service. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services
- Speech Therapist Services
- Therapeutic Foster Care Services

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Referrals for a Second Opinion - Medically Complex Children's Waiver

PCPs are required to refer a member for a second opinion at his or her request when surgery is recommended.

Referral Documentation - Medically Complex Children's Waiver

All referrals must be documented in the member's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services - Medically Complex Children's Waiver

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray Services[1]
- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services[2]

[1] FQHCs/RHCs that provide laboratory and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a prior authorization number on the claim form or the claim will be rejected.

[2] Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Some services still require a prescription or a physician's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements, or contact the SCDHHS Provider Service Center (PSC) by calling (888) 289-0709. Providers can also submit an online inquiry at https://scdhhs.gov/webform/contact-provider-representative and a provider support representative will respond to the request.

Primary Care Provider Requirements - Medically Complex Children's Waiver

The primary care provider is required to either provide services or authorize another provider to treat the member. The following Medicaid provider types may enroll as a primary care provider:

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Obstetrics and Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Practitioners

24-Hour Coverage Requirements - Medically Complex Children's Waiver

The MHN requires PCPs to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the member's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

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MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid prior to enrollment in a Managed Care Organization.. If the applicant meets the established Medicaid eligibility requirements, he or she may be eligible for participation in the South Carolina Medicaid Managed Care program. Not all Medicaid members will be eligible to participate in the Managed Care program.

The following Medicaid members are **not eligible** to participate in a South Carolina Medicaid **Managed Care**:

- Dually eligible Members (Medicare and Medicaid)*
- Members age 65 or older*
- Residents of a nursing home*
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants*
- PACE participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Members covered by an MCO/HMO through third-party coverage
- Members enrolled in another Medicaid managed care plan (Medical Home Network)

Providers should verify the member's eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.

*SCDHHS along with the Centers for Medicare and Medicaid Services (CMS) currently operate a dual demonstration grant, SC Healthy Connections PRIME, where Medicaid managed care enrollment of these membership groups are allowed. For more information regarding the SC Healthy Connections PRIME program please access the SCDHHS website https://scdhhs.gov/service/healthy-connections-prime.

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

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MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

OVERVIEW

All managed care enrollment and disenrollment activities are handled through one single point of contact, South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for processing the enrollment and disenrollment of Medicaid-eligible members into a managed care plan. Members may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid members are encouraged to actively enroll with a managed care plan.

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC website: www.SCchoices.com. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, an MCO regardless of how long a member has been enrolled in their current MCO.

Members who are eligible for managed care participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC.

An **enrollment packet** is mailed to members who are required to make a managed care plan choice. Failure to do so will result in managed care plan assignment by SCHCC.

An **outreach packet** is mailed to beneficiaries who are eligible, but not required, to participate in a managed care plan. Managed care participation is on a voluntary basis for this population. (See **Enrollment Counselor Services** later in this supplement.)

Outreach and assignment is based on the member's eligibility category and/or Special Program enrollment, member assignment to an MCO is done on a prospective basis.

If a Medicaid member enrolled in a MCO loses Medicaid eligibility, but regains it within sixty (60) days, he or she will be automatically reassigned to the same plan and will forego a new ninety (90) day choice period.

Members cannot enroll directly with the MCO. Members must contact SCHCC to enroll in a managed care plan, or to change or discontinue their enrollment. A member can only change or disenroll without cause within the first ninety (90) days of enrollment. If the member is approved to enroll in a managed care plan, or changes his or her plan, prior to SCDHHS' creation of the MCO member list which is done in the next to last week of each month, the member appears on the MCO's member listing in the next month. If the member is approved, and entered into the system in the last seven (7) to ten (10) days of the month, the member will appear on the plan's member listing for the following month.

ENROLLMENT PROCESS

Medicaid members receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, or thirty (30) to sixty (60) days prior to their annual Medicaid eligibility review. Members enrolled in a MCO will also receive a reminder letter from their health plan prior to their annual Medicaid eligibility review date.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

Members are always encouraged to open, read, and respond to the enrollment packets to avoid automatic MCO assignment. While managed care enrollment is encouraged during the annual eligibility review, FFS Medicaid beneficiaries may contact SCHCC to enroll at any time. They do not need to wait to receive enrollment information. Members enrolled in a managed care plan at the time of their annual review will remain in their MCO unless they contact SCHCC during their open enrollment (Ninety (90) day choice period) to request a change.

When enrollment packets are mailed, members have at least thirty (30) days from the mail date to choose an MCO. If a member fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the outreach efforts, a member still fails to respond, he or she will be assigned to a MCO.

The assignment process places members into MCOs available in the county where the member resides based on the following criteria:

- The MCO, if any, in which the beneficiary was previously enrolled
- The MCO, if any, in which family members are enrolled
- The MCO is selected by a Quality Weighted Automated Assignment Algorithm process if no health plan was identified

There are three easy ways for members to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at www.SCchoices.com

A member is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the MCO unless one of the following occurs:

- The member becomes ineligible for Medicaid and/or Managed Care enrollment
- The member forwards a written request to transfer plans for cause
- The member initiates the transfer process during the annual re-enrollment period
- The member requests transfer within the first ninety (90) days of enrollment

Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such, they are subject to being enrolled into a MCO. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO as the mother.

Babies automatically enrolled into the mother's MCO have a ninety (90) day choice period following birth during which a change to their health plan may be made. Following the ninety (90) day choice period, the newborn enters into his or her lock-in period and may not change MCOs for the first year of life without "just cause." The newborn's effective date of enrollment into a managed care plan is the first day of the month of birth.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

Primary Care Provider Selection and Assignment

Upon enrolling into a MCO, all beneficiaries are "assigned" to a primary care provider (PCP). When the member is assigned to an MCO, the MCO is responsible for assigning the PCP. After assignment, members may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled members may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area with the MCO to change their PCP. The name of the designated PCP will appear on all MCO cards. Should an MCO member change his/her PCP, he/she will be issued a new card from the MCO reflecting the new PCP.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

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MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

Members not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Members required to participate in managed care may only request to transfer to another MCO as fee-for-service Medicaid is no longer an option for the mandatory managed care population.

Disenrollment/transfer requests are processed through the enrollment broker, SCHCC. The member, the MCO or SCDHHS may initiate this process. During the 90 days following the date of initial enrollment with the MCO, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the first ninety (90) days following the date of initial enrollment has expired, members move into their "lock-in" period. Requests to change MCOs during the lock-in period are processed only for "just cause." Please refer to the MCO Policy and Procedures Guide and contract for additional information concerning just cause disenrollments.

Transfer requests made during the lock-in period require the completion of a Health Plan Change form, which may only be obtained by contacting SCHCC. The form requires the member to provide information confirming his or her attempt to resolve any issues necessitating disenrollment. That information includes documenting the date and time of the call to the MCO to discuss his or her issues, as well as the person with whom the member spoke. Failure to provide all required information will result in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS.

Upon review by SCDHHS, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the member in an effort to address the concerns raised in the request for disenrollment. MCOs are required to notify SCDHHS within ten (10) days of the follow-up results for all complaints or disenrollment requests forwarded to the plan. If just cause is not validated, disenrollment is denied and the member remains in the managed care plan. A member's request to transfer is honored if a decision has not been reached within sixty (60) days of the initial request. The final decision to accept the member's request is made by SCDHHS.

If the member believes he or she was disenrolled/transferred in error, it is the member's responsibility to contact SCHCC or the MCO for resolution. The member may be required to complete and submit a new enrollment form to SCHCC.

INVOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a MCO at any time deemed necessary by SCDHHS or the MCO, with SCDHHS approval.

The MCO's request for member disenrollment must be made in writing to SCHCC using all applicable form(s), and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the member's status. SCDHHS determines if the MCO has shown good cause to disenroll the member and informs SCHCC of

MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

their decision. SCHCC notifies both the MCO and the member of the decision in writing. The MCO and the member have the right to appeal any adverse decision. Providers should always check the Medicaid eligibility status of members before rendering service on the Medicaid Provider Web Tool.

The MCO may not terminate a member's enrollment because of any adverse change in the member's health. An exception would be when the member's continued enrollment in the plan would seriously impair the plan's ability to furnish services to either this particular member or other members.

For additional information, please review the involuntary disenrollment guidelines used by SCDHHS and the Managed Care plans in the **Disenrollment Process** section in the MCO Policy and Procedures Guide and contract.

MANAGED CARE SUPPLEMENT

EXHIBITS

MANAGED CARE PLANS BY COUNTY

All MCOs currently contracted with SCDHHS operate statewide.

The **Exhibits** section provides the contact information and a card sample for each MCO currently operating in South Carolina.

CURRENT MEDICAID MEDICAL HOMES NETWORKS (MHNS) FOR THE MEDICALLY COMPLEX CHILDREN'S WAIVER

The following MHN participates with the Medically Complex Children's waiver and South Carolina Healthy Connections Medicaid. MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

South Carolina Solutions

3555 Harden St Ext. Ste. 300
Columbia, South Carolina 29203
(888) 827-1665
www.sc-solutions.org

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Healthy Connections Medicaid MCOs are required to issue a plan identification card to enrolled members. Members should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the member (name, plan number), the MCO (toll-free contact numbers), and the PCP.

SAMPLE MEDICAID MCO CARDS

The following card samples are used by MCOs that are currently authorized to operate in South Carolina.

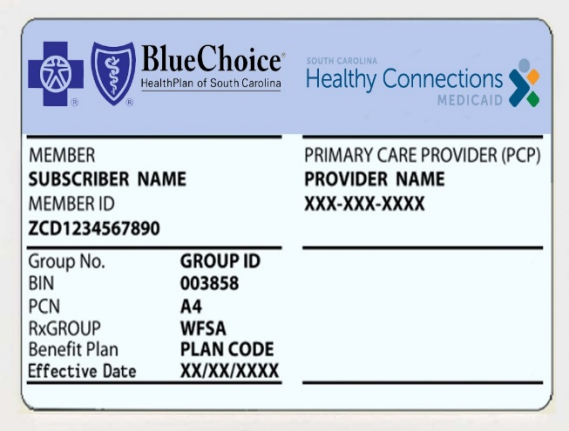
MANAGED CARE SUPPLEMENT

Absolute Total Care

Centene Corporation
(866) 433-6041
www.absolutetotalcare.com

Healthy Blue by BlueChoice

BlueChoice HealthPlan of South Carolina Medicaid
(866) 781-5094
www.bluechoicesc.com



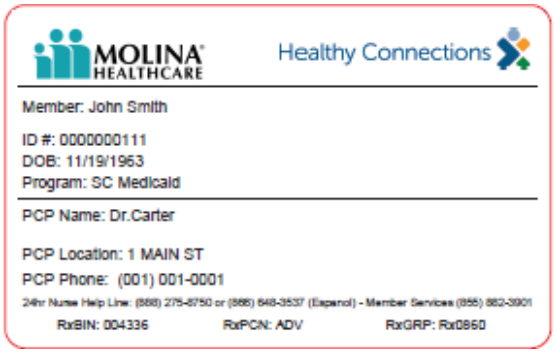
MANAGED CARE SUPPLEMENT

First Choice by Select Health

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com

Molina Healthcare, Inc.

1-855-882-3901
www.molinahealthcare.com



MANAGED CARE SUPPLEMENT

WellCare of South Carolina, Inc.

(888) 588-9842
www.southcarolina.wellcare.com

PROVIDER MANUAL SUPPLEMENT

THIRD-PARTY LIABILITY

TABLE OF CONTENTS

PROVIDER MANUAL SUPPLEMENT

THIRD-PARTY LIABILITY

TABLE OF CONTENTS

THIRD-PARTY LIABILITY SUPPLEMENT

INTRODUCTION

"Third-party liability" (TPL) refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. For the most part, this means providers are responsible for billing third parties before billing Medicaid.

Third parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State workers' compensation
- First party probate-estate recoveries

Private health insurers and Medicare are the most common types of third party that providers are required to bill. For information on casualty cases and estate recovery, see Section 1 of your provider manual.

HEALTH INSURANCE RECORDS

Medicaid Insurance Verification Services (MIVS), Medicaid's TPL contractor, researches third-party insurance information. Sources of information include providers, eligibility offices, long-term care workers, private insurers, other government agencies, and beneficiaries themselves.

It can take up to 25 days for a new policy record to be added to a beneficiary's eligibility file and five days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day.

ACCESS TO CARE

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid-eligible patient. You should ask every patient and/or the patient's responsible party about other insurance coverage.

According to 42 CFR 447.20(b), **you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance**. You and the patient should work together to decide whether you will consider the individual a Medicaid patient or a private-pay patient. If you accept the individual as a Medicaid patient, you are obligated to follow Medicaid's third-party liability guidelines and other policies. Remember, you agree to treat a patient as a Medicaid

patient for an entire spell of illness; you cannot change a beneficiary's status in the midst of a course of treatment.

When you first accept a Medicaid beneficiary, and at every service encounter thereafter, you will check to see whether the patient is eligible for Medicaid. At the same time, you will check for any other insurers you may need to bill. You should also perform a Medicaid eligibility check again when entering a claim, as eligibility and TPL information are constantly being updated.

South Carolina Healthy Connections (Medicaid) does not require you to obtain copies of other insurance cards from the beneficiary. You can obtain from South Carolina Healthy Connections (Medicaid) all the information you need to file with another insurer or to code TPL information on a Medicaid claim, including policy numbers, policy types, and contact information for the insurer, as long as Medicaid has that information on file.

Health Insurance Premium Payment Project

The Health Insurance Premium Payment (HIPP) project allows SCDHHS to pay private health insurance premiums for Medicaid beneficiaries who may be at risk of losing the private insurance coverage. SCDHHS will pay such premiums if the payment is deemed cost effective; see Section 1 of your provider manual for more information on qualifying situations. Maintaining good communication with your patients will help you identify candidates for referral to the HIPP program.

Eligibility Verification

- **Medicaid Card:** Possession of a Medicaid card means only that a beneficiary was eligible for Medicaid when the card was issued. You must use other eligibility resources for up-to-date eligibility and TPL information.
- **Point-of-Sale Devices and Eligibility Verification Vendors:** Check with your vendor to see how TPL information is reported.
- **Web Tool:** The Eligibility Verification function of the South Carolina Healthy Connections (Medicaid) Web-based Claims Submission Tool provides information about third-party coverage. See the Web Tool User Guide for instructions on checking eligibility.

REPORTING TPL INFORMATION TO MEDICAID

Providers are an important source of information from beneficiaries about third-party insurers. You can report this information to Medicaid in two ways: enter the information on claims submitted to Medicaid, or submit Health Insurance Information Referral Forms to Medicaid. When primary health insurance information appears on a claim form, the insurance information is passed to MIVS electronically for verification. This referral process is conducted weekly and contributes to timely additions and updates to the policy file.

THIRD-PARTY LIABILITY SUPPLEMENT

Health Insurance Information Referral Forms

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. You should fill out this form when you discover third-party coverage information that Medicaid does not know about, or when you have insurance documentation that indicates the TPL health insurance record needs an update.

A copy of the form is included in the Forms section of your provider manual, and samples appear at the end of this supplement. Send or fax the completed forms to:

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

COORDINATION OF BENEFITS

Health insurers adhere to "coordination of benefits" provisions to avoid duplicating payments. The health plan or payer obligated to pay a claim first is called the "primary" payer, the next is termed "secondary," and the third is called "tertiary." Together, the payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits.

Medicaid does not participate in coordination of benefits in the same way as other insurers. Medicaid is never primary, and it will only make payments up to the Medicaid allowable. However, you should understand how other companies coordinate payments.

COST AVOIDANCE VS. PAY & CHASE

South Carolina Healthy Connections (Medicaid) is required by the federal government to reject claims for which another party might be liable; this policy is known as "cost avoidance." Providers must report primary payments and denials to Medicaid to avoid rejected claims. The majority of services covered by Medicaid are subject to cost avoidance.

For certain services, Medicaid does not cost-avoid claims and will pursue recovery under a policy known as "Pay & Chase." Medicaid remains the payer of last resort in all cases; however, under Pay & Chase it temporarily behaves like a primary payer.

Services that fall under Pay & Chase are:

- Preventive pediatric services
- Dental EPSDT services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program. More information on recovery appears later in

this supplement. If you choose to bill both a third party and Medicaid, you must enter the TPL filing information on your Medicaid claim as outlined in this supplement – rendering Pay & Chase-eligible services does not exempt you from the requirement to correctly code for TPL.

Resources Secondary to Medicaid

Certain programs funded only by the state of South Carolina (*i.e.*, without matching federal funds) should be billed secondary to Medicaid. The TPL claim processing subsystem does not reject claims for resources that may pay after Medicaid. These resources are:

- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children's Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning (DHEC Maternal Child Health)
- DHEC Heart
- DHEC Hemophilia
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

COPAYMENTS AND TPL

For certain services, Medicaid beneficiaries must make a Medicaid copayment. SCDHHS deducts this amount from what Medicaid pays the provider. Copayments are described in detail in Section 3 of your provider manual (if they apply to the services you provide).

Remember, as a Medicaid provider you have agreed to accept Medicaid's payment as payment in full. You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. (You may, however, bill a beneficiary for services that Medicaid does not cover.)

When a beneficiary has Medicare or private insurance, he or she is still responsible for the Medicaid copayment. However, if the sum of the copayment and the Medicare/third-party payment would exceed the Medicaid-allowed amount, you must adjust or eliminate the copayment. In other words, though you may accept a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment cannot contribute to the excess revenue.

Medicaid beneficiaries with private insurance are **not** charged the copayment amount of the primary plan(s). When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect the Medicaid beneficiary by limiting his or her liability for payment for medical services.

THIRD-PARTY LIABILITY SUPPLEMENT

Medicaid determines payment in full and the patient's liability. Therefore, when you file a secondary claim with Medicaid, you can only apply the Medicaid copayment and cannot require the primary plan copayment as you would for a private pay patient.

DENIALS AND EOBS

When you bill a primary health insurer, you should obtain either a payment or a denial. You should also receive an Explanation of Benefits (EOB) that explains how the payment was calculated and any reasons for non-payment. Once you have received a reply from all potentially liable parties, if there are still charges that are not paid in full that might be covered by Medicaid, you may then bill Medicaid. This process is known as sequential billing.

Note that you must receive a *valid* denial before billing Medicaid. A request for more information or corrected information does not count as a valid denial.

POLICY TYPES

Each private policy listed in a patient's insurance record has an entry for "policy type," the most common of which is Health No Restrictions (HN). Another policy type you may encounter is HI, Health Indemnity; such policies pay per diem for hospital stays, surgeries, anesthesia, etc. HS, Health Supplemental, refers to policies that cover Medicare coinsurance and deductibles. Other policy types include Accident (HA) and Cancer (HC).

The policy type HN may be applied to a pharmacy carve-out, a mental health claim administrator, or a dental policy. The policy type does not provide specific information about the types of services covered, so you may have to take extra steps to determine whether to bill a particular carrier:

1. Ask the beneficiary. He or she should be able to tell you what kind of policy it is.
2. Look at the name of the carrier in the full list of carrier codes. The name may help you figure out the type of coverage (*e.g.*, ABC Dental Insurers).
3. Call SCDHHS Provider Service Center (PSC). Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider support representative will respond to you directly. He or she can look up more details of the plan in the TPL policy file.

TIMELY FILING REQUIREMENTS

Providers must file claims with Medicaid within a year of the date of service. If a claim is rejected, you must file a new claim within that year, and Void/Replacement adjustments must be made within that year as well – all activity related to the claim must occur within a year of the date of service in order for you to be paid.

Because of this timely filing requirement, you should bill third parties as soon as possible after service delivery. SCDHHS recommends that you file a claim with the primary insurer within 30 days of the date of service.

THIRD-PARTY LIABILITY SUPPLEMENT

Regardless of how long the third party takes to reply, providers must still meet Medicaid's timeliness requirements. Delays by other insurers are not a sufficient excuse for timeliness extensions.

Timely Filing	
Medicaid claims	One year
Medicare-primary claims to Medicaid	Two years or within six months from Medicare adjudication
Primary health insurance	30 days recommended

Late claim filing to the primary insurer and gaps in activity related to obtaining payment from a primary carrier are not reasonable practices. SCDHHS will not consider payment if a claim is not successfully adjudicated by the MMIS within the time frames above.

REASONABLE EFFORT

Providers occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. It is your responsibility as a provider to seek a solution to such problems.

"Reasonable effort" consists of taking logical, timely steps at each stage of the billing process. Such steps may include submitting new claims, making follow-up phone calls, and sending additional requested information. Many resources are available to help you pursue third-party payments. The PSC can work with you to explore these options.

Reasonable Effort and Insurance Companies

Below is a suggested process for filing to insurance companies. A flowchart based on this process can be found at the end of this supplement.

A. Send a claim to the insurance company.

If after **thirty days** you have received no response:

B. Call the company's customer service department to determine the status of the claim.

- **If the company has not received the claim:**
  1. Refile the claim. Stamp the claim as a repeat submission or send a cover note.
  2. Repeat follow-up steps as needed.
- **If the company has received the claim but considers the billing insufficient:**
  1. Supply all additional information requested by the company.
  2. Confirm that all requested information has been submitted.

THIRD-PARTY LIABILITY SUPPLEMENT

3. Allow thirty more days for the claim to be processed.
4. If there is no response within thirty days and all information has been supplied as requested, proceed as instructed below.

- **If the company has received the claim, considers the billing valid, and has not suspended the claim:**
  1. Make a note in your files.
  2. Follow up with a written request for a response.

C. If after two more weeks you have still received no response:

1. Write to the company citing this history of difficulties. Copy the South Carolina Department of Insurance Consumer Division on your letter.

Remember, difficulties with insurance companies do not exempt you from timely filing requirements. It is important that you file a claim as soon as possible after providing a service so that, should you encounter any difficulty, you have time to pursue the steps described above.

Once the Department of Insurance has resolved an issue (which usually takes about 90 days), you should have adequate information to bill Medicaid correctly. Following all the steps above should take no more than 180 days, well within the Medicaid timely filing limit of one year.

Reasonable Effort and Beneficiaries

Difficulties can arise when a beneficiary does not cooperate with an insurer's request for information. For example, U.S. military beneficiaries must report changes in their status and eligibility to the Defense Eligibility and Enrollment Reporting System (DEERS); a delay by a beneficiary may delay a provider's response from the insurer. An insurer may also need a beneficiary to send in subrogation forms related to a hospitalization.

It is in your interest to contact the beneficiary, whether by phone, certified letter, or otherwise. You may offer to help the beneficiary understand and fill out forms. Be sure to document all your attempts at contact and inform the insurer of such actions.

Occasionally insurers will pay a beneficiary instead of a provider. If you know an insurance payment will be made to a patient, you should consider having the patient sign an agreement indicating that the total payment will be turned over to the provider, and that failure to cooperate with the agreement will result in the beneficiary no longer being accepted as a Medicaid patient.

Reasonable Effort Documentation Form

In cases where you have made all reasonable efforts to resolve a situation, you can submit a Reasonable Effort Documentation form. The form must demonstrate that you have made sustained efforts to contact the insurance company or beneficiary. This document is used only as a last resort, when all other attempts at contact and payment collection have failed.

Attach the form to a claim filed as a denial. Attach copies of all documents that demonstrate your efforts (correspondence with the insurer and the Department of Insurance, notes from your files, etc.). If you are filing electronically, you must keep the Reasonable Effort Documentation form

and all supporting documentation on file. A blank Reasonable Effort Documentation form can be found in the Forms section of your provider manual, and examples appear at the end of this supplement.

REPORTING TPL INFORMATION ON CLAIMS

When you file a claim that includes TPL information, you will report up to five pieces of TPL information, depending on the type of claim:

For each insurer:

1. The carrier code
2. The insured's policy number
3. A payment amount or "0.00"

For the whole claim:

4. A denial indicator when at least one payer has not made payment
5. The total of all payments by other insurers

Carrier Codes

Medicaid, in conjunction with the South Carolina Hospital Association (SCHA), assigns every third-party insurer a unique three-digit alphanumeric code. Among the SCHA carrier codes are a few five-digit codes created by SCDHHS to satisfy carrier-specific claim filing requirements; these are identified by the suffix RX (pharmacy plans). SCHA carrier codes are used to identify insurers and other payers (including the Medicare Advantage plans) on dental, professional, and institutional claims. A complete list of carrier codes can be found in Appendix 2 of those provider manuals.

SCDHHS maintains an entirely separate list of five-digit carrier codes for pharmacy claims submission. Providers should visit http://southcarolina.fhsc.com or the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the pharmacy carrier codes list.

With very few exceptions, the alphanumeric carrier codes assigned by the SCHA are three digits, alpha-numeric-alpha. However, if you file hard copy, you may want to indicate a zero as Ø to ensure it is keyed correctly.

If you cannot find a particular carrier or carrier code in your manual, please visit the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the most current carrier codes list.

If you are billing a company for which you cannot find a code, you may use 199, the generic carrier code. MIVS will then call you to ask about the new insurer. You may prefer to submit a Health Insurance Information Referral Form to MIVS while you have the carrier information easily accessible, as MIVS may call you up to one month after the claim has been processed.

You may encounter the "CAS" carrier code when checking a beneficiary's eligibility. This code represents an open casualty case. Medicaid does not cost avoid claims with casualty coverage. You may decide to bill Medicaid directly and forgo participation in the case, or you may take

action with the liable party and not bill Medicaid. Timely filing requirements still apply even where there is a possible casualty settlement, so you must make your decision prior to the one-year Medicaid timely filing deadline.

Policy Numbers

Many insurance companies use Social Security numbers (SSNs) as policy numbers, but some are transitioning to policy numbers that do not rely on confidential information. You should use the number that appears on the beneficiary's health insurance card.

SCDHHS has begun adding these new policy numbers to beneficiary records. If one of your claims is rejected for failure to file to a private insurer (edit 150) and you have already filed to that insurer, there may be a policy number discrepancy; you should code the claim with the beneficiary's SSN. Edit codes and rejected claims are discussed in more detail below.

PHARMACY CLAIMS

TPL policies apply to all Medicaid services. Like other providers, pharmacists must bill all other potentially liable parties, including Medicare, before billing Medicaid. However, pharmacists' billing procedures differ from those of other providers. Pharmacists do not use the carrier codes assigned by the SCHA; South Carolina Healthy Connections (Medicaid) maintains separate carrier codes for pharmacy claims submission. Providers should visit the SCDHHS Provider Information page at http://provider.scdhhs.gov for pharmacy carrier codes. These unique codes may also be found at http://southcarolina.fhsc.com.

Pharmacists receive two-character NCPDP edit codes rather than South Carolina Healthy Connections (Medicaid) edit codes. Code 41 indicates that you need to file to a third-party payer, to include Medicare Parts B and D, if applicable.

Pharmacy services are generally cost-avoided; however, SCDHHS performs Pay & Chase billing for insurance resources that are Child Support Enforcement-ordered and in situations where the insurance company will not pay the Medicaid-assigned claim and instead makes payment to the subscriber. Pharmacists who file to primary plans but do not receive the insurance payment should report that fact to MIVS or SCDHHS so that Pay & Chase may be implemented instead of cost avoidance.

The point-of-sale contractor's Pharmacy Provider Manual contains complete instructions on how to submit TPL information on Medicaid claims.

NURSING FACILITY CLAIMS

Nursing facilities are required to follow Medicaid's TPL policies by billing other liable parties before billing Medicaid. The nursing facility claim form, the Turn Around Document, does not provide fields for coding TPL information. In order to have TPL payments calculated, you will report TPL payments and denials on a Health Insurance Information Referral Form and/or submit the insurance EOB with a new DHHS Form 181.

If you discover third-party coverage that Medicaid does not yet have on file, bill the third party and send a Health Insurance Information Referral Form to MIVS so that the insurance record

THIRD-PARTY LIABILITY SUPPLEMENT

may be put online. If Medicaid has already paid, you are responsible for refunding the insurance payment. Failure to report insurance that will likely be subsequently discovered may result in the claim being put into benefit recovery and recouped in a recovery cycle (see the section on recovery for more information).

To initiate Medicaid billing for a resident also covered by a third-party payer, submit a claim to Medicaid and receive a rejection (edit code 156 for commercial insurance) for having failed to file with the other liable third parties. This establishes your willingness to accept a resident as a Medicaid beneficiary. It also shows that you intend to adhere to Medicaid's timely filing requirements.

When you receive a rejected claim, attach all EOBs and submit a new DHHS Form 181 to the Medicaid Claims Control System (MCCS); they will route it to the Medicaid TPL department for processing. If you are subsequently paid by a third party, use Form 205 to refund part or all of your Medicaid payment. Mark "health insurance" as the reason for the refund, supply the insurance information, and attach a check for the amount being refunded.

Remember that claims in recovery have timely filing requirements. SCDHHS suggests that as soon as you receive a 156 edit and/or discover that a resident has third-party coverage, you check your records and bill the third party for previous claims for the current calendar year and for one year prior for which Medicaid should not have paid primary. If you wait for the next recovery cycle, you may run into timely filing deadlines. All previously paid claims that were not filed with the insurance company or third parties are subject to recovery by Medicaid.

Should MIVS mail you a letter of recovery, make sure you follow all procedures and timelines as required. The PSC will be able to assist you in completing all requirements from MIVS in order to avoid a take-back or to reverse a previous take-back.

If you have any other questions or concerns about third-party liability issues, call the PSC. Because nursing home billing cycles are often longer than those of other providers, it is essential that you contact SCDHHS early in the TPL billing process, before timely filing requirements become a concern.

The Nursing Facility Services Provider Manual contains complete billing instructions for nursing facilities. Please see also the following sections of this supplement: Eligibility Verification, Reporting TPL Information to Medicaid, Cost Avoidance vs. Pay & Chase, Timely Filing Requirements, and Reasonable Effort.

PROFESSIONAL, INSTITUTIONAL, AND DENTAL CLAIMS

The CMS-1500 and UB-04 claim forms have space to report two payers other than Medicaid. If there are three or more insurers, you will need to code your claim with the payers listed that pay primary and secondary. When your claim receives edit 151, you must submit a new claim and write in the carrier code, policy number, and amount paid in the third occurrences of fields 24, 25, and 26 of the CMS-1500, Claims submitted electronically will be processed automatically with up to ten primary payers.

THIRD-PARTY LIABILITY SUPPLEMENT

Professional Paper Claims

The CMS-1500 has two areas for entering other insurers: block 9 (fields 9a, 9c, and 9d) and block 11 (fields 11, 11b, and 11c). If there is only one primary insurer, you can use either block. If there are two insurers, use both blocks.

CMS-1500 TPL Fields

9a Other Insured's Policy or Group Number Enter the policy number.	**11 Insured's Policy Group or FECA Number** Enter the policy number.
9c Reserved for NUCC Use If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.	**11b Other Claim ID (Designated by NUCC)** If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
9d Insurance Plan Name or Program Name Enter the three-character carrier code.	**11c Insurance Plan Name or Program Name** Enter the three-character carrier code.

10d Claim Codes (Designated by NUCC) Enter the appropriate TPL indicator for this claim.

The valid TPL indicators are:

- **1** Insurance denied
- **6** Crime victim
- **8** Uncooperative beneficiary

If either insurer denied payment, you will put the TPL indicator "1" in field 10d. "6" is used to alert SCDHHS to potential criminal proceedings and restitution. "8" is used in conjunction with the Reasonable Effort Documentation form to show that you have been unable to contact a beneficiary from whom you need information and/or payment.

29 Amount Paid Enter the total amount paid from all insurance sources. This amount is the sum of 9c and 11b.

Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Institutional Paper Claims

Unlike other claim types, the UB claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 31, 32, 33, or 34.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

UB-04 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		$33.01
B	401 (BCBS carrier code)		$255.39
C	619 (Medicaid carrier code)		

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-04 with TPL information appears at the end of this supplement.

Dental Paper Claims

For samples and complete instructions for filling out the ADA and CMS-1500 claim forms, refer to the DentaQuest Dental Office Reference Manual (ORM) at http://www.DentaQuest.com

THIRD-PARTY LIABILITY SUPPLEMENT

Web-Submitted Claims

The Web Tool User Guide contains instructions for entering TPL information for all claim types except Dental using the Web Tool. The basic steps are the same as for paper claims.

REJECTED CLAIMS

If you file a claim to Medicaid for which you should have first billed a third-party insurer, your claim will be rejected unless 1) the policy has not yet been uploaded to the MMIS, or 2) the service is in Pay & Chase. The Eligibility section on the Web Tool will supply information you need to file with the third-party payer.

Insurance Edits

There are six edit codes indicating that a claim has not been filed to other insurers:

- 150: TPL coverage verified/filing not indicated on claim
- 151: Multiple insurance policies/not all filed – call TPL
- 155: Possible, not positive, insurance match/other errors
- 156: TPL verified/filing not indicated on claim
- 157: TPL coverage; no amount other sources on claim
- 953: Buy-in indicated – possible Medicare payer

If you receive one of these edit codes and have not filed a claim with all third parties listed under the Eligibility section on the Web Tool, you must do so. **Whenever you receive one of these edits, your subsequent attempts to obtain Medicaid payment must have at least one TPL carrier code and policy number even when there is no primary payment.** If a policy has lapsed by the time a claim is processed, SCDHHS will be unable to correctly identify the claim as TPL-related unless you enter the TPL information on a new claim.

The insurance carrier code, the policy number, and the name of the policyholder are all listed under the Eligibility section on the Web Tool, while the carrier's address and telephone number may be found in Appendix 2 of your provider manual or on the SCDHHS Web site. Because of timely filing requirements, you should file with the primary insurer as soon as possible.

If you have already filed a claim with all third parties listed on the Web Tool, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the rejected claim and submit a new claim. You must re-enter all TPL information when filing a new claim.

Other TPL-related edit codes include:

165: TPL balance due/patient responsibility must be present and numeric

316: Third party code invalid

317: Invalid injury code

390: TPL payment amount not numeric

400: TPL carrier and policy number must both be present

THIRD-PARTY LIABILITY SUPPLEMENT

401: Amount in other sources, but no TPL carrier code

555: TPL payment is greater than payment due from Medicaid

557: Carrier payments must equal payments from other sources

565: Third-party payment, but no third-party ID

690: Amount from other sources more than Medicaid amount

732: Payer ID number not on file

733: Insurance information coded, but payment or denial indicator missing

953: Buy-in indicated on CIS – possible Medicare

Resolution instructions for these edit codes can be found in Appendix 1 of your provider manual.

CLAIM ADJUSTMENTS AND REFUNDS

If you are paid by a third-party insurer after you have been paid by Medicaid, you should initiate a claim adjustment if you wish to refund the original paid claim in full. You must use the Void/Replacement rather than the Void Only option. Unless there is a replacement claim, new TPL information will not be available to MIVS for investigation and addition to the policy file in the MMIS.

If the refund is for an amount less than the original Medicaid payment, contact MIVS for a manual TPL debit or send a refund check for the appropriate amount. Complete instructions for filing adjustments are in Section 3 of your provider manual, and sample Adjustment Form 130s appear at the end of this supplement. Please remember that hospital providers, pharmacists, and nursing facilities do not use the Form 130.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

Remember: you should not send a check when you make a claim-level adjustment. However, if you need to send a reimbursement check for any reason, fill out the Form for Medicaid Refunds (Form 205 – see the Forms section of your provider manual) and send it with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
PO Box 8355
Columbia, SC 29202

RECOVERY

"Recovery" refers to all situations where Medicaid or the provider pursues third parties who are liable for claims that Medicaid has already paid. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase.

MIVS is responsible for mailing recovery invoices and posting benefit recovery responses. If you have questions about recovery, please contact them directly. See the contact list at the end of the supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Medicare

SCDHHS invoices institutional and professional medical providers at the beginning of each month for retroactive Medicare coverage (Retro Medicare). You will receive a letter indicating that your account will be debited. The letter identifies Medicare-eligible beneficiaries, claim control numbers, and dates of service, as well as the check date of the automated adjustment and an "own reference number" to identify the debit(s).

You are expected to file the affected claims to Medicare within 30 days of the invoice. After filing to Medicare, you have the option of filing a claim to Medicaid for consideration of an additional payment toward the coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit.

If Medicare has denied, you may submit a claim to Medicaid. Provider adjustments will not be submitted for payment in order to eliminate the possibility of duplicate payments. Certain claims for patients with Medicare Part B only, when it is impossible to file them within the one-year timely filing limit, may be an exception.

Despite the extended timely filing deadlines for Medicare-primary claims (six months from Medicare payment or two years from the date of service), you may encounter difficulties with timely filing when Medicare does not make a payment and a claim is in Retro Medicare. If a claim sent to Medicaid is denied with edit 510 for being more than one year after the date of service or six months after the Medicare remittance date, mail, or fax the rejected claim, with supporting documentation to MIVS. If the patient is Part B-only and a UB claim form has received edit 510, the rejected claim, with supporting documentation, should be forwarded or faxed to MIVS. If MIVS determines that the late filing is valid, they will make a credit adjustment.

Claims pulled into Retro Medicare, when filed within 30 days should meet Medicare one year timely filing rule.

Please note that the computer logic also reviews the procedures on the claims and does not pull into recovery procedure codes that are not Medicare covered.

South Carolina Healthy Connections (Medicaid) is responsible for attempting to recover all claims that can be filed within timely filing limits.

Retro Health and Pay & Chase

SCDHHS invoices institutional providers each month for Retro Health and Pay & Chase claims. Providers are expected to file the claims to the primary medical plan within the month of the invoice and to respond to the recovery letter upon receiving the primary adjudication.

One month after the first recovery letter, providers are notified of any claims for which there has been no response. Three months after the first invoice, claims for which there was no response are automatically debited. Requests for reconsideration of the debit must be received within 90 days of the debit. SCDHHS will not reconsider requests after the nine-month cycle.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Health Example

January 2018	Initial invoice
February 2018	Second letter
March 2018	Notification: Automated debit on last check date of the month

You should submit claims promptly to the primary carriers to avoid receiving timely filing denials from the primary health plans for cost avoidance and for recovery. If you fail to meet timely filing requirements and thus fail to meet a primary carrier's deadline, this is not an acceptable denial; however, when an insurer's timely filing deadline for a date of service is within approximately six weeks of an invoice in Retro Health or possibly before the Medicaid invoice, SCDHHS will accept the insurer's denial and stop a subsequent debit of the Medicaid paid claim from your account.

Insurers occasionally recoup payments made to providers who have put the insurance payment on a Medicaid secondary claim or who have refunded the Medicaid primary payment under Retro Health or Pay & Chase. When the provider submits proof of return of the primary payment, SCDHHS will consider reinstating payment by manual adjustment when the request is received within 90 days of the primary plan request to the provider.

CONCLUSION

Medicaid's ability to fund health care for low-income people relies in part on the success of its cost avoidance measures. For providers, third-party liability responsibilities can be summarized as follows:

- Bill all other liable parties before billing Medicaid.
- Make reasonable, good-faith efforts to get responses from insurers and beneficiaries.
- Code TPL information correctly on claims.

THIRD-PARTY LIABILITY SUPPLEMENT

TPL RESOURCES

The PSC is your first source for questions about third-party liability. Listed below are some other resources.

Dental Claims: Provider questions about third party liability should be directed to the DentaQuest Call Center at 1-888-307-6553 or via e-mail at denclaims@dentaquest.com.

SCDHHS Web site: http://www.scdhhs.gov

- Carrier codes
- Provider manuals
- Edit codes and resolutions

Provider Enrollment and Education Web site: http://MedicaideLearning.com

- Web Tool User Guide and Addenda

Medicaid Insurance Verification Services

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804
Email: MIVS@BCBSSC.com

Main Number	1-888-289-0709 option 5
Other Health Insurance	1-888-289-0709, option 5, option 1 803-252-0870 Fax
Fund Recovery	1-888-289-0709, option 5, option 1 803-462-2582 Fax
General Correspondence	1-888-289-0709, option 5, option 1 803-462-2583 Fax

Casualty, Estate Recovery, and HIPP Correspondence

South Carolina Healthy Connections
PO Box 100127
Columbia, SC 29202-3127

Casualty	1-888-289-0709, option 5, option 2 803-462-2579 Fax
Estate Recovery	1-888-289-0709, option 5, option 3 803-462-2579 Fax

THIRD-PARTY LIABILITY SUPPLEMENT

Health Insurance Premium Payment Project (HIPP)	1-888-289-0709, option 5, option 4 803-462-2580 Fax
Special Needs Trust	1-888-289-0709, option 5, option 5 803-462-2579 Fax

South Carolina Department of Insurance

300 Arbor Lake Drive, Suite 1200
PO Box 100105
Columbia, SC 29223
http://www.doi.sc.gov/

THIRD-PARTY LIABILITY SUPPLEMENT

SAMPLE FORMS

Form
Health Insurance Information Referral Form: Carrier change
Health Insurance Information Referral Form: Coverage ended
Reasonable Effort Documentation Form: Failure to respond – beneficiary
Reasonable Effort Documentation Form: Failure to respond – insurer
Reasonable Effort Flowchart
Adjustment Form 130: Primary insurer paid after the appeal process
Adjustment Form 130: Primary insurer payment received after Medicaid payment
UB-04: Medicare paid; private insurer denied
CMS-1500: Two private insurers; one paid, one denied
CMS-1500: Medicare and private insurer paid

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/10

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: Jim Smith Date Referral Completed: 02/29/2010

Medicaid ID#: 222222222 Policy Number: AZ99999999999

Insurance Company Name: OmniCorp Insurers Group Number: 390-OP-777777

Insured's Name: N/A Insured SSN: 777-77-0000

Employer's Name/Address: Retired

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

__X__ b. beneficiary coverage ended - terminate coverage (date) 12/31/2009

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN

(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax: 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL, Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/2010

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: John Doe Date Referral Completed: 02/28/2010

Medicaid ID#: 9999999999 Policy Number: DH123456

Insurance Company Name: National Dental Insurance Group Number: QWE1234

Insured's Name: Jane Doe Insured SSN: 123-45-6789

Employer's Name/Address: South Carolina State Library, 1500 Senate Street, Columbia, SC 29201

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

____ a. beneficiary has never been covered by the policy – close insurance.

____ b. beneficiary coverage ended - terminate coverage (date) _____

____ c. subscriber coverage lapsed - terminate coverage (date) _____

__X__ d. subscriber changed plans under employer - new carrier is GloboChem

- new policy number is A1111111110

____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN

(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax: 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL, Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Acme Orthopedic **DOS** 01/01/10

NPI or MEDICAID PROVIDER ID 1234567890

MEDICAID BENEFICIARY NAME Jane Doe

MEDICAID BENEFICIARY ID# 1111111111

INSURANCE COMPANY NAME Jones Health Insurance

POLICYHOLDER Jane Doe

POLICY NUMBER 987654321J

ORIGINAL DATE FILED TO INSURANCE COMPANY 01/15/10

DATE OF FOLLOW UP ACTIVITY 02/16/10

RESULT:
Called insurer to check claim status. Insurer needs bene to fill out subrogation forms

FURTHER ACTION TAKEN:

Called beneficiary on 02/16/10, 02/18/10, and 02/28/10. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

DATE OF SECOND FOLLOW UP 03/05/10

RESULT:

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/08; they will not act without forms.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

Mary Orthopod 03/12/10

(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Dr. Betty Smith **DOS** 03/05/10

NPI or MEDICAID PROVIDER ID 1231231230

MEDICAID BENEFICIARY NAME John Jones

MEDICAID BENEFICIARY ID# 9999999999

INSURANCE COMPANY NAME Global Health

POLICYHOLDER John Jones

POLICY NUMBER 8888888888

ORIGINAL DATE FILED TO INSURANCE COMPANY 03/07/10

DATE OF FOLLOW UP ACTIVITY 04/06/10

RESULT:
Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 04/10/10.

FURTHER ACTION TAKEN:

04/27/10: No response from insurer. Called again; they could not find claim. Resubmitted on 04/29/10.

DATE OF SECOND FOLLOW UP 05/30/10

RESULT:

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/10. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

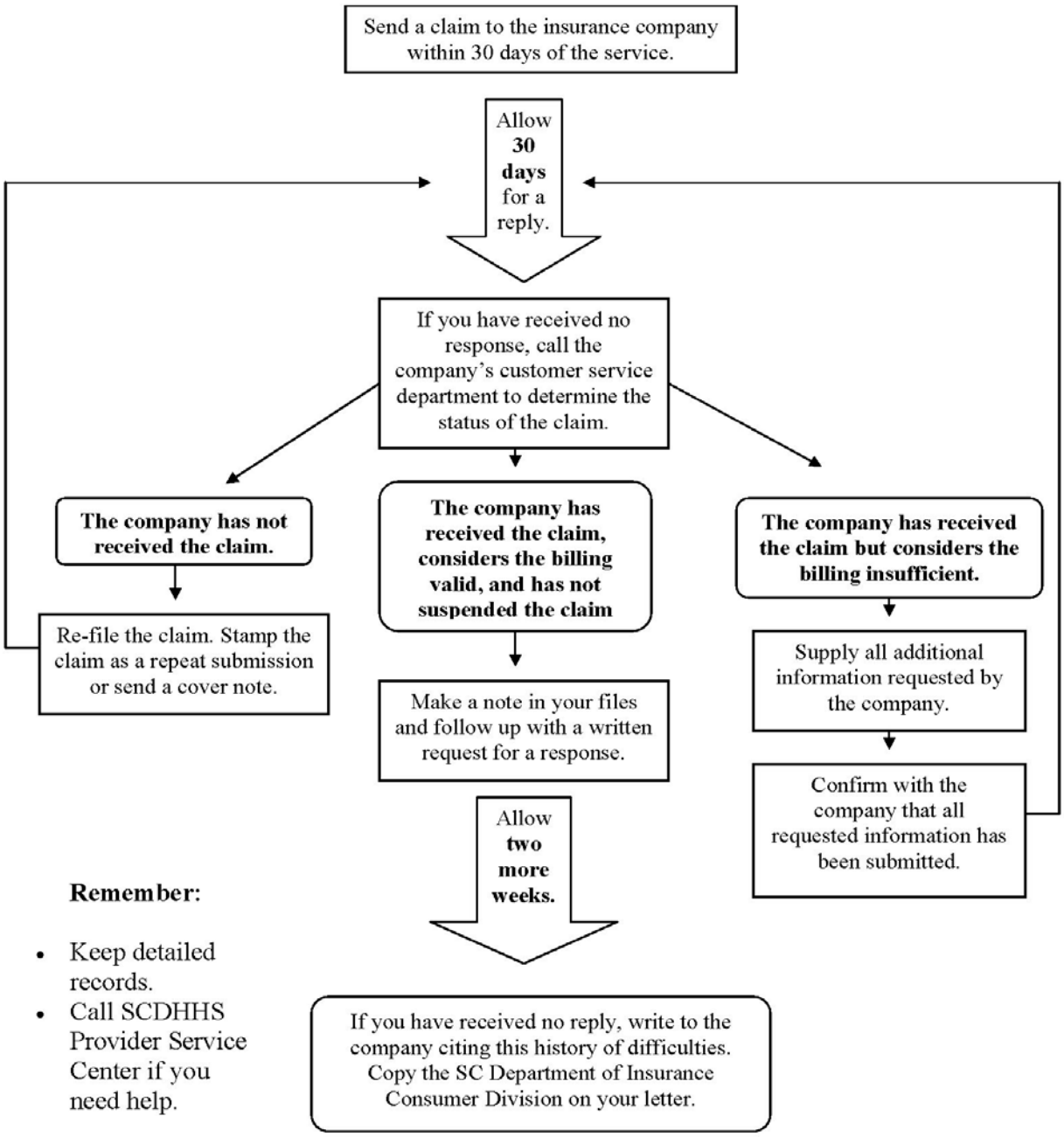
Betty Smith 06/03/10
(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

How to Obtain a Response from Insurance Company
A Suggested Third-Party Filing Process



Remember:

- Keep detailed records.
- Call SCDHHS Provider Service Center if you need help.

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Johnson DME Supply

Provider Address :

111 Oak Lane

Provider City , State, Zip:

Anywhere, SC 22222-2222

Total paid amount on the original claim:

$1244.00

Original CCN:

5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

Provider ID:

A B C 1 2 3

NPI:

1 2 3 4 5 6 7 8 9 0

Recipient ID:

2 2 2 2 2 2 2 2 2 2

Adjustment Type:

○ Void ● Void/Replace

Originator:

○ DHHS ○ MCCS ● Provider ○ MIVS

Reason For Adjustment: (Fill One Only)

- ● Insurance payment different than original claim
- ○ Keying errors
- ○ Incorrect recipient billed
- ○ Voluntary provider refund due to health insurance
- ○ Voluntary provider refund due to casualty
- ○ Voluntary provider refund due to Medicare
- ○ Medicaid paid twice - void only
- ○ Incorrect provider paid
- ○ Incorrect dates of service paid
- ○ Provider filing error
- ○ Medicare adjusted the claim
- ○ Other

For Agency Use Only

Analyst ID:

- ○ Hospital/Office Visit included in Surgical Package
- ○ Independent lab should be paid for service
- ○ Assistant surgeon paid as primary surgeon
- ○ Multiple surgery claims submitted for the same DOS
- ○ MMIS claims processing error
- ○ Rate change
- ○ Web Tool error
- ○ Reference File error
- ○ MCCS processing error
- ○ Claim review by Appeals

Comments:

Primary insurer paid after the appeal process.

Signature: Jane Doe Date: 04/01/10

Phone: (555) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Dr. Joe Jones

Provider Address :

123 Main Street

Provider City , State, Zip:

Somewhere, SC 22222-0000

Total paid amount on the original claim:

$230

Original CCN: 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A

Provider ID:

NPI: 9 8 7 6 5 4 3 2 1 0

Recipient ID: 7 7 7 7 7 7 7 7 7 7

Adjustment Type:

○ Void ● Void/Replace

Originator:

○ DHHS ○ MCCS ● Provider ○ MIVS

Reason For Adjustment: (Fill One Only)

- ○ Insurance payment different than original claim
- ○ Keying errors
- ○ Incorrect recipient billed
- ● Voluntary provider refund due to health insurance
- ○ Voluntary provider refund due to casualty
- ○ Voluntary provider refund due to Medicare
- ○ Medicaid paid twice - void only
- ○ Incorrect provider paid
- ○ Incorrect dates of service paid
- ○ Provider filing error
- ○ Medicare adjusted the claim
- ○ Other

For Agency Use Only

Analyst ID:

- ○ Hospital/Office Visit included in Surgical Package
- ○ Independent lab should be paid for service
- ○ Assistant surgeon paid as primary surgeon
- ○ Multiple surgery claims submitted for the same DOS
- ○ MMIS claims processing error
- ○ Rate change
- ○ Web Tool error
- ○ Reference File error
- ○ MCCS processing error
- ○ Claim review by Appeals

Comments:

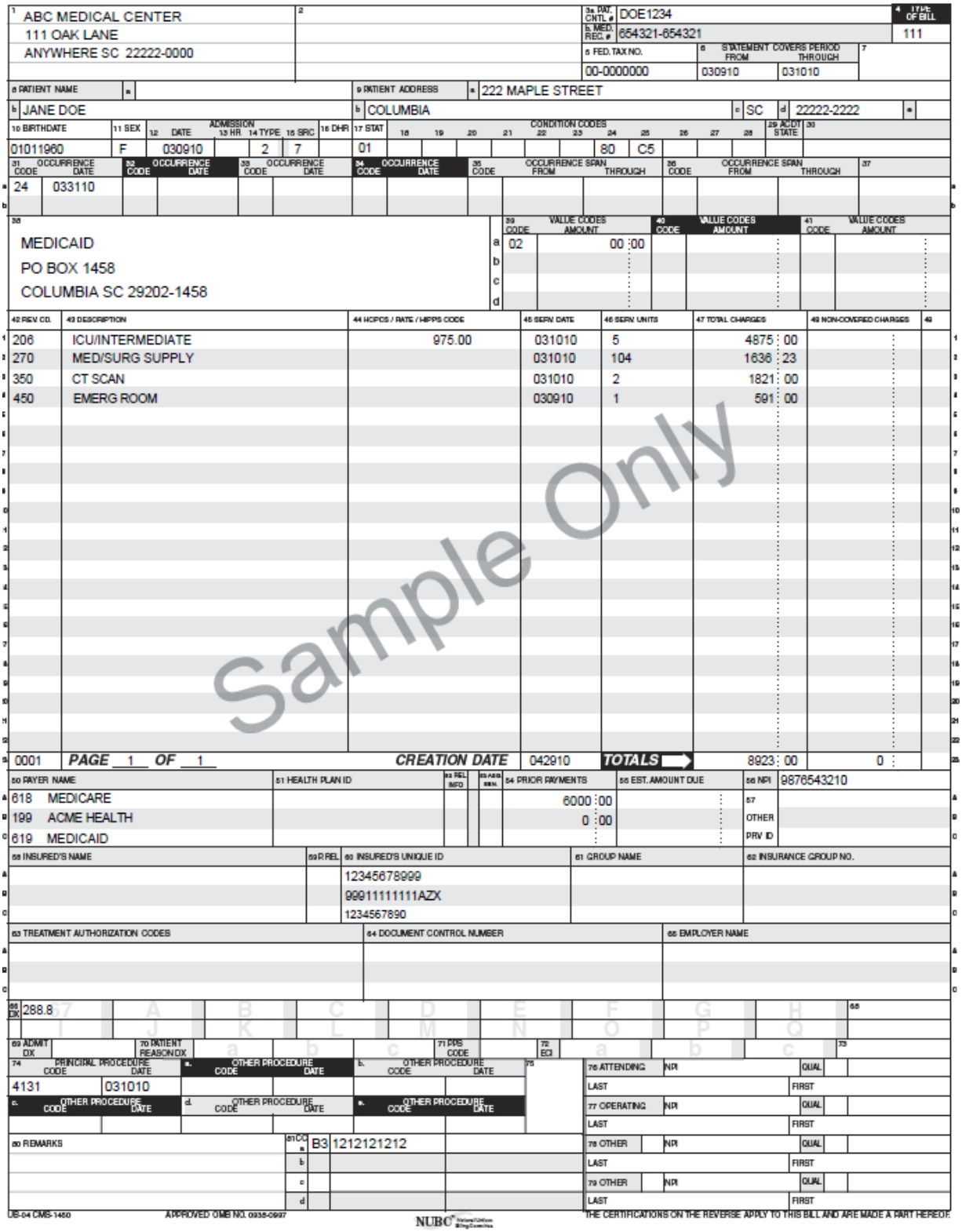
Primary insurance payment received after Medicaid payment.

Signature: *Mary Smith* Date: 04/01/10

Phone: (803) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT



1 ABC MEDICAL CENTER
111 OAK LANE
ANYWHERE SC 22222-0000

3a PAT. CNTL # DOE1234
b. MED. REC. # 654321-654321
4 TYPE OF BILL 111
5 FED. TAX NO. 00-0000000
6 STATEMENT COVERS PERIOD FROM 030910 THROUGH 031010

8 PATIENT NAME: JANE DOE
9 PATIENT ADDRESS: 222 MAPLE STREET
b COLUMBIA c SC d 22222-2222

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01011960	F	030910		2	7		01							80	C5					

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	24	033110													
b															

38 MEDICAID
PO BOX 1458
COLUMBIA SC 29202-1458

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	02	00 00				
b						
c						
d						

	42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	206	ICU/INTERMEDIATE	975.00	031010	5	4875 00		
2	270	MED/SURG SUPPLY		031010	104	1636 23		
3	350	CT SCAN		031010	2	1821 00		
4	450	EMERG ROOM		030910	1	591 00		
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	042910	TOTALS	8923 00	0	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A	618 MEDICARE				6000 00		57 OTHER	
B	199 ACME HEALTH				0 00		PRV ID	
C	619 MEDICAID							

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			12345678999		
B			99911111111AZX		
C			1234567890		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

	66 DX	67	A	B	C	D	E	F	G	H	68
	288.8	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
4131	031010					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

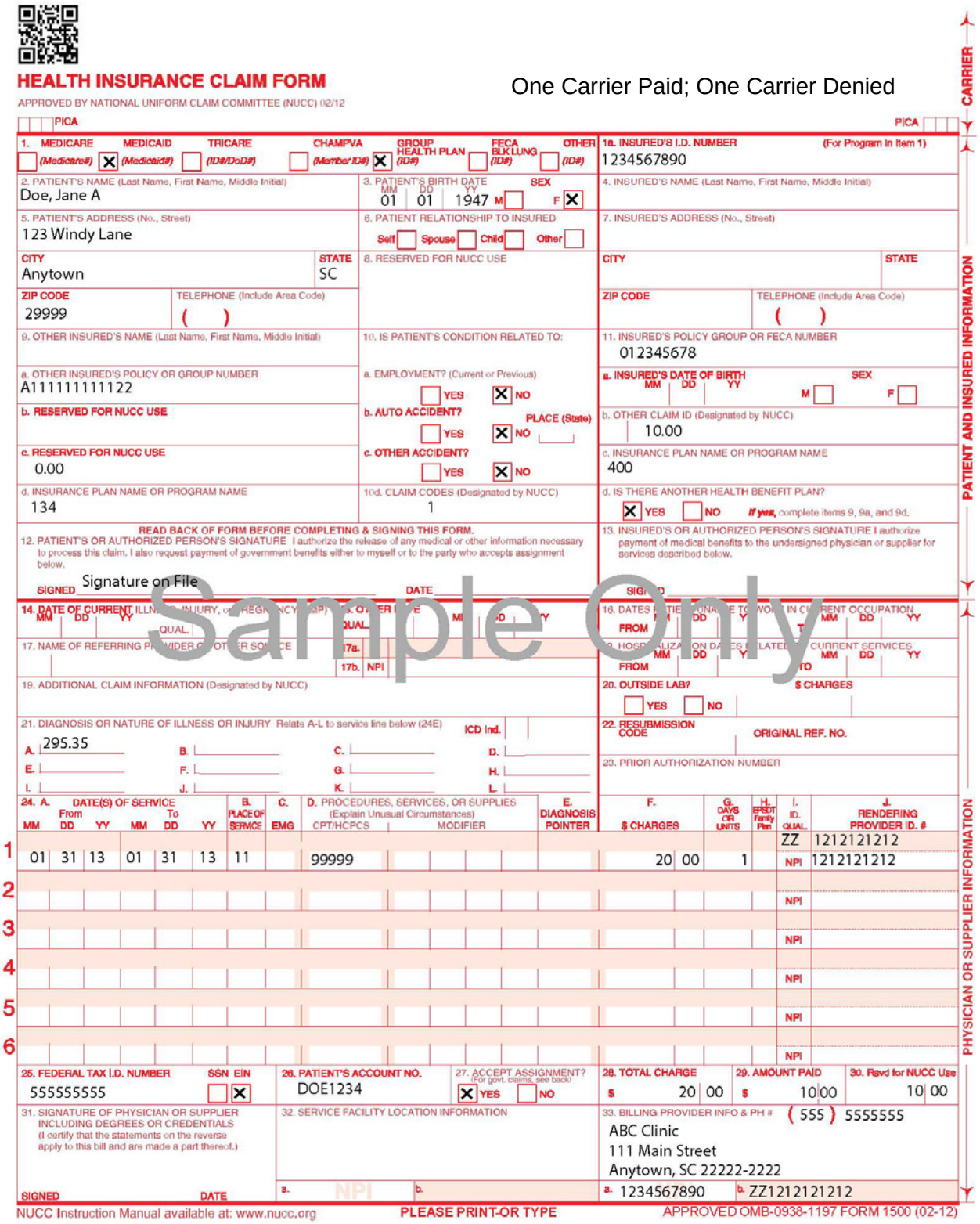
80 REMARKS

81CC		
a	B3	1212121212
b		
c		
d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

THIRD-PARTY LIABILITY SUPPLEMENT



HEALTH INSURANCE CLAIM FORM

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

One Carrier Paid; One Carrier Denied

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1947 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

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

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

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 012345678

a. OTHER INSURED'S POLICY OR GROUP NUMBER: A111111111122

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 0.00

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: 400

d. INSURANCE PLAN NAME OR PROGRAM NAME: 134

10d. CLAIM CODES (Designated by NUCC): 1

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE

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 QUAL. MM DD YY

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. 295.35 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999			20 00	1		ZZ	1212121212
															NPI	1212121212
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 555555555

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 10 00

30. Rsvd for NUCC Use 10 00

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 # (555) 5555555

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

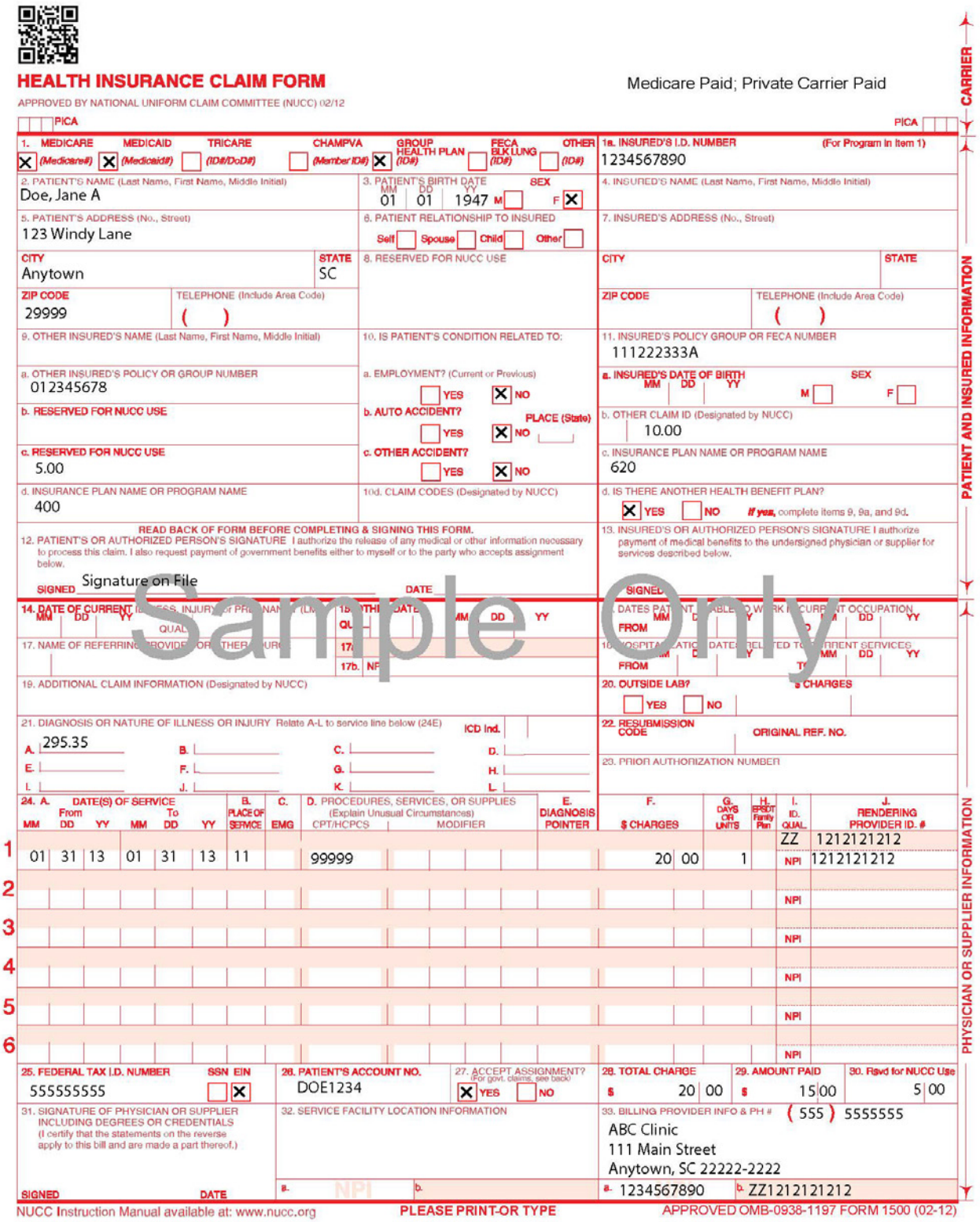
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

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

THIRD-PARTY LIABILITY SUPPLEMENT



HEALTH INSURANCE CLAIM FORM

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

Medicare Paid; Private Carrier Paid

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1947 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

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

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

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 111222333A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 012345678

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 5.00

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: 620

d. INSURANCE PLAN NAME OR PROGRAM NAME: 400

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE

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 QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. 295.35 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999			20 00	1		ZZ	1212121212
															NPI	1212121212
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 15 00

30. Rsvd for NUCC Use 5 00

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 # (555) 5555555

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

Sample Only

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THIRD-PARTY LIABILITY SUPPLEMENT

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