TITLE PAGE

Part I A – Technical Proposal	
RFP Title:	Third Party Administrative Services
RFP:	3086
Vendor Name:	***CorrectCare-Integrated Health, Inc.***
Address:	***366 South Broadway*** ***Lexington, KY 40508***
Proposal Opening Date:	December 12, 2013
Proposal Opening Time:	2:00 PM

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VENDOR INFORMATION SHEET

VENDOR INFORMATION SHEET FOR RFP 3086

Vendor Must:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 will be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Tab III of the Technical Proposal.

V1	Company Name	CorrectCare-Integrated Health, Inc.

V2	Street Address	366 South Broadway

V3	City, State, ZIP	Lexington, Kentucky 40508

V4	Telephone Number		
	Area Code: 859	Number: 225-7999	Extension:

V5	Facsimile Number		
	Area Code: 859	Number: 226-0554	Extension:

V6	Toll Free Number		
	Area Code: 877	Number: 367-2067	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: Linda Goins
	Title: President
	Address:
	Email Address:

V8	Telephone Number for Contact Person		
	Area Code: 859	Number: 225-7999	Extension:

V9	Facsimile Number for Contact Person		
	Area Code: 859	Number: 226-0554	Extension:

V10	***Name of Individual Authorized to Bind the Organization***

	Name: Linda Goins	Title: President

V11	Signature ***(Individual must be legally authorized to bind the vendor per NRS 333.337)***	
	Signature:	Date:

STATE DOCUMENTS

State of Nevada
Department of Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Greg Smith
Administrator

SUBJECT:	Amendment 1 to Request for Proposal 3086
RFP TITLE:	Third Party Administrative Services
DATE OF AMENDMENT:	November 22, 2013
DATE OF RFP RELEASE:	October 24, 2013
OPENING DATE:	December 12, 2013
OPENING TIME:	2:00 PM
CONTACT:	Marcy Troescher, Procurement Staff Member

The following shall be a part of RFP ***3086.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

---

1. Please identify the current TPA Fee.

FY 14 rate is $2.66 per inmate per month based on an estimated 12,667 monthly average population.

2. Please identify the reason for RFP - i.e. performance issues, service, etc.?

The current contract amendment, extending the original contract, expires June 30, 2014. Contract lengths are defined in NRS Chapter 333, NAC Chapter 333 and SAM 0300. There were no specific performance issues or service issues.

3. Please identify the last month's enrollment?

Last month's enrollment was 12,808.

4. Please identify the number of claims processed in the current fiscal year?

The current fiscal year (FY14) runs from 7/1/2013 to 6/30/2014. 17,006 claims have been processed year to date through 11/15/2013.

5. Section 3.1.7 Is NVDOC policy to only use designated computers to access the claims system? Is there a policy for internet use?

NDOC does have a policy for internet use; however, accessing claims systems through Department computers from contracted providers is a permitted use.

6. Section 3.1.7 Our system is .net, any computer with a web browser can access our claims system. Does NVDOC require the vendor to pay for a dedicated line?

   See answer to #5. NDOC does not require vendor to pay for a dedicated line.

7. Sec 3.3.3 The system must allow access to provider's database for UR determinations. Question: Describe the UR determinations for which access to the database is required?

   The requirement was not stated completely. The system must have a field for Utilization Review Panel authorization codes, and the system should be able to be queried by NDOC personnel by those codes for historical purposes.

8. What is the current/estimated population to be served?

   Current projected population for FY 14 is 12,667 per month.

9. Over the past two years what is the monthly enrollment and also the monthly total of claims paid for the covered population. Note, we are interested in claim count more that paid claim dollars.

   The average monthly population for FY12 was 12,428 and the total number of claims processed for the fiscal year was 40,096. The average monthly population for FY 13 was 12,605 and the number of claims processed for the fiscal year was 41,183.

10. Who is the current administrator?

    Zenith American Solutions.

11. What is the administrative fee and list of services currently in place?

    FY 14 fee is $2.66 per inmate per month. The third party administrator (TPA) is required to process medical and dental claims for inmates who have had health care services and treatments outside the prison or from outside providers. The TPA interfaces with the NDOC contracted Preferred Provider Organizations to re-price the claims and then pays the claims from an NDOC-funded bank account. NDOC does its own utilization review.

12. What is the State Department of Corrections looking to improve upon in considering a change in administrators?

    See #2 above.

13. Is the State Department of Corrections interested in looking at network alternatives as well?

    Not at this time.

14. Is integration with a PBM required? If so, who is the PBM?

No. The Department has its own central pharmacy.

15. Is integration with other vendors required? If so, who are they and what is required of the TPA?

    Yes, integration with other vendors is required. The current networks contracted by NDOC are Hometown Health in the northern region and Multiplan in the southern region. The TPA must be able to exchange claims information and re-pricing data with the networks.

16. Who will provide UR determinations? Is that to be included in the admin services?

    NDOC will do the UR determinations. That is not to be included in the admin services.

17. What is the current plan of medical and dental benefits? Is this a 100% of allowed amount benefit for both medical and dental?

    NDOC uses the Hometown Health and Multiplan networks for the northern region and southern region respectively, and uses their respective contracted rates with their network providers.

18. Are any cost management programs utilized beyond UR Determinations? If so, who provides these?

    Yes. The current TPA uses software to insure that unbundling does not occur.

19. Section 3. Is Nevada participating in Medicaid expansion and/or will all inpatient stays be Medicaid eligible?

    Inmates are not eligible for Medicaid; however, if an inmate is admitted to a medical facility for more than 24 hours, then they are no longer considered an inmate for Medicaid purposes. The Department will apply for Medicaid on their behalf if they are otherwise eligible for Medicaid. Most inmates under the Affordable Care Act will fall into the expanded eligibility group for those inpatient stays in medical facilities.

20. Claims statistics. Please provide three years of data separated by PPO. If the data cannot be separated by PPO, then three years of combined data will suffice. The following data is requested: (1) number of claims received further broken down into paid claims and no-pay claims ; (2) number of claims received by EDI versus paper; (3) and the number of institutional versus professional claims.

21.

Calendar Year				Fiscal Year		
Year	Adjustments	EDI Claims	Average % Auto Adjudicated	Fiscal Year	Total # of Claims Paid	$ Amount of Claims Paid
2011	1727	31318	58%	FY12	40,096	$ 11,182,792
2012	114	N/A	71%	FY13	41,183	$ 12,319,487
2013 (YTD)	199	22812	56%	FY14 (YTD)	17,006	$ 9,672,673

In addition, 12% of all claims received are non-paid and 2.2% of all claims received are institutional and the balance is professional.

22. Claims statistics. Please provide three years of the following combined data (not separated by PPO): (1) number of refunds processed; (2) number of supplemental payments to providers if any, requested by the NDOC; (3) percent of claims completely auto-adjudicated; and (4) percent of claims partially auto-adjudicated (i.e., started auto-adjudication but could not be completed without human intervention).

Please see table in Question #20. Refunds and supplemental payments are not tracked separately, but are included in adjustments. Partially auto-adjudicated claims are not tracked separately.

23. Please discuss and describe in as much detail as possible any significant changes anticipated by the NDOC in the annual claims volume and/or inmate count in the next four years due to increased Medicaid eligibility, legislation and/or operational or facility changes.

The inmate count is anticipated to remain flat for the next four years. There has been an average of 250 hospital stays per year for the past few years. Due to the expanded eligibility of inmates in Medicaid for inpatient stays in medical facilities (as discussed in #19), there should be a lower number of claims processed for the next four years.

24. Section 3.2.3. Please provide the layout of the inmate identifier file.

The inmate identifier file is simply a list of all inmates, their identifying information, and their dates of incarceration, used by our current TPA to determine eligibility. The variables sent are:

-Offender ID
-First Name
-Middle Name
-Last Name
-Birth Date
-Gender
-Race
-Location
-Booking Begin Date
-Booking End Date

-Imprison Status
-Imprison Status State

25. Section 3.1.6. In regards to interfacing with the PPO to re-price claims, will the vendor have an actual electronic interface with each PPO to send and receive claims data for re-pricing, or will each PPO provide contracts to load into the vendor's claims system, or will the vendor have to go out to a website provided by each PPO and manually enter claims data to obtain re-pricing?

    The NDOC TPA currently sends claims data electronically to Hometown Health for re-pricing and is working on the same procedure with Multiplan. Multiplan allows manual re-pricing on their website.

26. If the provider is out of network (non-par), how is the claim paid (% of Medicaid, % of Medicare, contracted rate, etc.)? What percent of claims are non-par?

    Out-of-network claims are covered by a wrap network or negotiated by the PPO. If those options do not cover the claims, then Usual & Customary is used or finally billed charges. Non-par claims were 6.9% of the total.

27. What clearinghouse(s) does the current vendor use to receive claims submitted electronically by providers?

    HCRnet, Emdeon, WebMD, LabCorp, Proxymed, Healthsmart, SSI

28. Section 3.10. Claims processed within 14 working days. Please provide a more detailed definition of claims processed. For instance, is this service and performance standard just applicable for "clean" claims and if so, what is your definition of a "clean" claim?

    Definition of claims processed would be: Claim received by vendor, loaded into the system, re-priced, and check run presented to NDOC for approval. This is applicable to all claims. The standard is 90% which would account for some variation in turnaround time. A clean claim is a claim that has all applicable information loaded in the system and the claim is ready to pay – authorization on file, provider loaded, re-pricing attached.

29. Section 3.10. Turnaround performance standard. Please explain whether the end date for the turnaround time is when the claim is finalized and the register is sent to NDOC for approval or when the payment check is actually issued? Does the same standard apply for denied claims with the end date being when the denial letter and EOP is sent?

    Turnaround time for the performance standard is defined by when the claim is finalized and the register sent to NDOC for approval. The same standard applies for denied claims.

30. Section 3.10.1. What is the incumbent's average turnaround time of claims processing?

    The incumbent's turnaround is: 90% of all claims have been paid within 30 days of receipt, which includes NDOC's check register approval time.

31. In section 3.3 Utilization Review Requirements, the RFP references data that needs to be stored in the TPA system. Does NDOC have a document defining the data that will be provided from the Utilization Review system? How often with the TPA be receiving data from the NDOC Utilization Review system?

The UR data is sent to the TPA via Excel spreadsheet once per week.

32. In section 3.3 Utilization Review Requirements, please clarify what is meant by 3.3.2.3 List of inmates by authorization code. Typically there is one code for an episode (multiple claims) or encounter (one claim) but this requirement appears to suggest that there are multiple inmates associated with one authorization.

    In most instances, there is one authorization code per inmate per visit; however, for onsite clinics one authorization number is issued for each clinic.

33. In section 3.3 Utilization Review Requirements, please provide more information on 3.3.5.3 – A follow up listing for concurrent review. Typically, the stay will be completed before the claim is received. Can you provide an example of how this is done currently or what information you are looking for on this listing?

    Please disregard Section 3.3.5.3.

34. Please provide information on the claims payment process – from the submittal of a claims register by the vendor to NDOC to the funding by NDOC of a claims paying account. Furthermore, how frequently does NDOC expect a claims register, and how long does it take the NDOC to fund the account? Will NDOC fund the account by check sent through the mail or by ACH?

    The claims payment process occurs on a weekly cycle. The current claims are processed Monday through Friday. A check register is generated and released to NDOC for final approval the following Monday. NDOC reviews and approves the check register during the week received. The account is funded concurrently with the approval process. The account is funded through electronic funds transfer.

35. Will Boarders be included in the monthly inmate population counts?

    Yes.

36. For claims for Boarders, will the vendor just process those claims and mail them to the sending jurisdiction for payment?

    No. The vendor will process those claims. NDOC will pay those claims and then seek reimbursement from the responsible jurisdiction

37. Are there any special reporting, and/or reporting segregation requirements for Boarders?

    No.

38. What historical claims information will the incumbent provide to the awarded vendor, and for what period of time?

    The incumbent will provide a file of all historical data to the awarded vendor.

39. Please provide the inmate counts for the last three fiscal years that are used for calculating the administrative fee. Also, provide any projected inmate counts.

Fees are based on the monthly population. FY 12 rate was $2.50 per inmate per month based on an average population of 12,428. FY 13 rate was $2.58 per inmate per month based on an average monthly population of 12,605. FY 14 is $2.66 per inmate per month based on an estimated monthly population of 12,667.

40. Section 3.1.5. The amount of the TPA bond is dependent on the amount the awarded vendor will pay annually in claims. Please provide the dollar amount of claims that have been paid by the incumbent for the last two years. Furthermore, can the awarded vendor increase the amount of their TPA bond if necessary before the contract starts or does the amount of the TPA bond need to be in place before the proposal is submitted?

    See table in Question #21 for dollar amount of claims that have been paid by the incumbent for the past two years. Yes, the awarded vendor can increase the amount of their TPA bond if necessary prior to the contract start date.

ALL ELSE REMAINS THE SAME FOR RFP 3086.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: CorrectCare-Integrated Health, Inc.

Authorized Signature: _____

Title: Linda Goins, President Date: _____

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **will not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information.

In accordance with the Submittal Instructions of this RFP, vendors are requested to submit confidential information in separate binders marked "**Part I B Confidential Technical**" and "**Part III Confidential Financial**".

The State will not be responsible for any information contained within the proposal. Should vendors not comply with the labeling and packing requirements, proposals will be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that will be in an open meeting format, the proposals will remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act will constitute a complete waiver and all submitted information will become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information as defined in ***Section 2 "ACRONYMS/DEFINITIONS."***

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part I B – Confidential Technical Information			
YES		NO	***X***
Justification for Confidential Status			

A Public Records CD has been included for the Technical and Cost Proposal			
YES	***X***	NO	

Part III – Confidential Financial Information			
YES	***X***	NO	
Justification for Confidential Status			
This section contains the company's audited financial statements for 2011 and 2012 and the company's interim financial statements through October 2013. Since CCIH is a privately held company, this information is not publicly available and any release of this information could seriously harm the company's competitive position.			

Company Name: CorrectCare-Integrated Health, Inc.

Signature:

Print Name: Linda Goins, President

Date: 12/9/2013

This document must be submitted in Tab IV of vendor's technical proposal

ATTACHMENT C – VENDOR CERTIFICATIONS

Vendor agrees and will comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and will not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, will remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, will remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals must be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion must be in writing and included in the proposal at the time of submission.

(7) Each vendor must disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict should be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of a vendor's proposal. An award will not be made where a conflict of interest exists. The State will determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and will be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor must certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal must be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

CorrectCare-Integrated Health, Inc.

Vendor Company Name

Vendor Signature

Linda Goins, President

Print Name

Date

This document must be submitted in Tab IV of vendor's technical proposal

WLT SOFTWARE END USER LICENSE AGREEMENT

CC 523

END USER SOFTWARE LICENSE AGREEMENT
BY AND BETWEEN
WLT SOFTWARE OF FLORIDA, INC.
AND
CORRECTCARE, INC.

Contract Number NCWIN-4104

THIS AGREEMENT is made and entered into this 16 day of January, 2006, by and between WLT Software of Florida, Inc., being located at 831 North Hercules Avenue, Clearwater, Florida 33765 (hereinafter referred to as "WLT") and CorrectCare, Inc., being located at 366 South Broadway, Lexington, Kentucky 40508 (hereinafter referred to as "Client").

RECITALS:

WLT has agreed to license to Client a certain data processing software system(s), described in the appropriate sections of this End User Software License Agreement and the parties wish to place their oral discussions into written form.

This Agreement shall become effective on the date and year first written once it has been properly executed by both parties.

IT IS THEREFORE AGREED:

I. THE FOLLOWING PROGRAMS SHALL BE INCLUDED AS THE LICENSED PROGRAMS FOR PURPOSE OF THIS AGREEMENT:

1. MEDICLAIMS FOR WINDOWS

A. LICENSED PROGRAMS

WLT agrees to license to Client the computer software system(s) as listed herein (hereinafter referred to as the "Licensed Programs").

B. TERMS

WLT agrees to deliver the Licensed Programs to Client within Sixty (60) Days from the effective date of this Agreement. If at any time, WLT is delayed in the performance of its obligations under this Agreement because Client is not available to answer questions, Client requests the delay, or because Client has not provided the agreed upon data for the proper and timely progression of work on the Licensed Programs, or for any other reason(s) beyond the control of WLT, the completion date shall be postponed by the number of working days WLT was so delayed.

WLT shall not be responsible for delays in the implementation of the Licensed Programs resulting from acts of God, strikes, lockouts, disruption in transportation media, employee death or any other cause which is outside the reasonable control of WLT.

Client Initials ____ WLT Initials ____ Page 1

WLT SOFTWARE OF FLORIDA, INC.
INSURANCE SOFTWARE SPECIALISTS

C. COST AND PAYMENT

The 5-User License Fee for the Licensed Programs shall be Fifty Thousand Dollars ($50,000.00), plus ongoing maintenance costs and any applicable interest as noted herein. Additional users may be added in blocks of Five (5) for One Thousand Five Hundred Dollars ($1,500.00) per user.

Payment shall be due to WLT from Client as follows:

___✓___ 1. Twenty Five Thousand Dollars ($25,000.00) shall be due and payable to WLT from Client upon the signing of this Agreement.

Twenty Five Thousand Dollars ($25,000.00) shall be due and payable to WLT from Client upon the completion of initial training and the start of live processing or no later than March 1, 2006.

Five (5) Days of initial training at WLT's location are included in this Agreement. However, if training is held at Client's location, Client shall be billed for all costs incurred for travel, meals, lodging, transportation and any overtime related to said training. Any additional training shall be billed at the rate of One Thousand Dollars ($1,000.00) per day, or the current pricing at the time of the training, plus expenses. Payment for such costs shall be due from Client within Thirty (30) Days of invoice from WLT.

Client may incur charges from WLT and/or outside vendor(s) for integration and/or updates of data supplied by WLT and/or outside vendors including, but not limited to: Usual and Customary Tables, Average Wholesale Drug Pricing Tables, and ICD-9 Files for use within the License Programs.

Client is responsible for any applicable tax.

D. WARRANTY

WLT warrants that any defect in programming of the Licensed Programs, resulting from WLT's work on the Licensed Programs, shall be corrected by WLT with no additional charge to Client as long as Client maintains a valid and current Maintenance Agreement with WLT. Should WLT expend time, monies and or services at Client's request to correct an alleged defect only to find that no defect exists or that the defect was introduced by Client or another party, such time shall be billed at the hourly programming rate in effect at the time the problem occurs.

WLT shall, at its expense, defend any Infringement Action brought against Client to the extent that such action is based on a valid claim that the Licensed Program(s) as referenced within the scope of this Agreement infringe(s) on any United States patent or copyright: provided, however, WLT's obligations under this Section are conditioned upon Clients promptly notifying WLT, in writing, via certified or registered mail return receipt requested of the Infringement Action and all prior claims relating thereto and WLT shall have sole control of the defense and all negotiations for compromise of any Infringement Action.

Except for the foregoing as described in the previous two paragraphs in this Section D, titled Warranty, WLT makes no warranties or representations, expressed or implied, including but not limited to the implied warranty of merchantability and fitness for a particular purpose. Under no circumstances shall WLT be liable for incidental, consequential, special or exemplary damages of any kind or for lost profits, increased

Client Initials WLT Initials TB Page 2

WLT SOFTWARE OF FLORIDA, INC.
INSURANCE SOFTWARE SPECIALISTS

expenditures, or legal expenses arising out of the use or nonuse of the programs provided by or through WLT.

WLT does not warrant that Client's use of the Licensed Programs will be uninterrupted or error free.

WLT supplies no warranties as to accuracy, completeness or currentness, with respect to the Licensed Programs and or any related services or items offered or provided including, without limitation, any third party products, end user support services or any content that may be accessed, indexed, and/or downloaded by operation of the Licensed Programs.

In the event of any breach of this Agreement by WLT, WLT shall have no liability for damages or indemnity in any amount exceeding the charges paid by Client to WLT for the Licensed Programs. In no event, regardless of the form of the action, whether in contract or in tort, including negligence, shall WLT be liable for any incidental damages, consequential damages, or lost profits. Notwithstanding the fact that WLT may have been advised of the possibility of such damages. In addition, WLT shall not be liable for any claim or demand against Client by any other party.

E. WLT'S RESPONSIBILITY

It is expressly understood and agreed that work on the Licensed Programs shall be solely performed by WLT and/or its designated agents and/or employees, who at no time and under no circumstances are to be considered employees or agents of Client. WLT and/or its agents shall at all times maintain an independent contractor relationship with Client.

In order that WLT and/or its agents may fulfill the requirements of implementing the Licensed Programs, it may be necessary for Client to disclose to WLT confidential proprietary information pertaining to the past, present, and future activities of Client. WLT agrees to use all reasonable controls to protect Client's confidential information, if provided by Client to WLT, consistent with the manner in which WLT protects its own confidential business information.

F. CLIENT'S RESPONSIBILITY

Client hereby agrees that WLT has demonstrated or offered to demonstrate the Licensed Programs to Client and Client agrees that the Licensed Programs meet Client's requirements. It is expressly understood and agreed that Client shall be solely responsible for the content and accuracy of all data input for use of the Licensed Programs and shall further be responsible for the verification of all output reports and data from the Licensed Programs. In addition, Client shall be solely responsible for daily backup and storage of Client's own data.

In the event Client does not pay to WLT any and or all sum(s) as noted herein, in the manner as noted herein, Client shall be responsible for any and all legal expenses and or fees associated with any collection and/or attempted collection of said sum(s).

Client shall be solely responsible for providing the Data Processing Equipment (Hardware) that is required for utilization of the Licensed Programs in conformance with WLT's written guidelines hereby included as Attachment "A" and made a part of this Agreement.

Client Initials WLT Initials TB Page 3

Client shall appoint one of its employees as Project Manager. Said individual shall work with a representative or representatives of WLT to furnish, in a timely manner, all information reasonably deemed necessary by WLT to complete the production and/or delivery of the Licensed Programs. If WLT does not receive notice of the identity of the Project Manager within Ten (10) Days following the date of this Agreement, Client will be deemed to have appointed as the Project Manager the person who has signed this Agreement on behalf of Client.

Client agrees to put forth its best and most diligent effort in providing WLT with any and all information necessary to assure that the Licensed Programs are installed and utilized by Client in an expedient manner.

Client is aware that the Licensed Programs are delivered and installed "as is" unless otherwise specified in an Addendum to this Agreement, being fully executed by the party (ies) as referred herein, and that any other custom programming requests, not included herein, will be reviewed following Client going live on the Licensed Programs.

Client hereby acknowledges that Client will not use the licensed program to compete with WLT.

Client hereby acknowledges that it currently has or will implement Internet capabilities within Sixty (60) Days from the signing of this Agreement.

G. CONVERSIONS/CUSTOM PROGRAMS/ENHANCEMENTS/REVISIONS

WLT agrees to provide reasonable consulting and/or programming assistance when feasible, and at WLT's discretion, to Client for work done on a data conversion. In the event WLT supplies conversion programs or other custom programs in addition to those outlined in this Agreement and any attached addenda to Client, Client will be billed for said programs at WLT's programming rate in effect at the time the programs are written. All custom programs, enhancements and revisions to the Licensed Programs, become and are one and the same as the Licensed Programs and remain solely and exclusively the property of WLT. Client will not delay acceptance or installation of the Licensed Programs on the basis that Client's files are not prepared or that Client is waiting for custom programming to install or go live on the licensed programs, unless said programming and/or delays are reflected in an Addendum and attached to this Agreement, as long as WLT can demonstrate that the Licensed Programs are operational and as demonstrated.

H. PROPERTY RIGHTS AND NONDISCLOSURE

Grant of License: Subject to Client's compliance with the terms and conditions contained in this End User Software License Agreement WLT grants to Client a nonexclusive, nontransferable License to use its proprietary Licensed Programs, accompanying electronic, on-line, and/or written documentation, reports and related materials for Client's own lawful use. The Licensed Programs may be installed by Client at one (1) site and on one (1) computer controlled by Client or one (1) network server allowing only Client and other authorized representatives or customers of Client who have agreed to the proprietary and confidentiality terms and conditions of this Agreement to access the Licensed Programs, manuals and/or related materials.

Client Initials WLT Initials TB Page 4

Ownership of the Licensed Programs and Related Materials: WLT owns all title and proprietary rights in and to the Licensed Programs, manuals and related materials and all copies thereof, all of which contain valuable trade secrets of WLT. This License is NOT a sale of the Licensed Programs, manuals and/or related materials or any copy thereof, nor a waiver of the rights of WLT under the United States copyright laws or any other federal, state or other applicable laws. This License does not include the right to sublicense the Licensed Programs, and/or any portions thereof, manuals and/or related material and is personal to Client's organization, and therefore may not be assigned, by operation of law or otherwise, or otherwise transferred by Client without the prior written consent of WLT. Without limiting the foregoing, Client may not at any time or for any purpose sell, give, trade, license, sublicense, lend, rent, lease, or otherwise transfer or make available to its subsidiaries or any other party the Licensed Programs or any portions thereof, manuals or any related materials. Client acknowledges that the Licensed Programs in source code form and the related materials remain a confidential trade secret of WLT, and Client agrees not to reverse engineer, decipher, decompile, copy, modify or disassemble the Licensed Programs, except as authorized by law, incorporate the Licensed Programs, in whole or in part, in any other software product, or develop derivative works of the Licensed Programs or allow others to do so, or to attempt to do any of the foregoing, without the express prior written consent of WLT.

In the event of any violation of any item as referenced herein, Client hereby agrees to pay WLT ten (10) times the cost of WLT's license fee in effect, at the time of the discovery, for each occurrence.

Restriction of Copying: Client may not copy the Licensed Programs or permit others to copy the Licensed Programs, except for a maximum of two (2) copies to be used solely for and by Client for backup or archival purposes. Any such copy (ies) made shall be subject to this Agreement and shall contain all of WLT's notices regarding copyright, trademarks, and other proprietary rights as contained in the Licensed Programs originally provided to Client. Client may not remove any proprietary rights, usage rights, disclaimer or warning notices included in or embedded in any part of the Licensed Programs or in any copy thereof.

Ownership of Accessed Content: All title, ownership rights and proprietary rights in and to the information and other content accessed, indexed and or downloaded from the Internet or World Wide Web by operation of or use by the Licensed Programs is the property of the applicable content owner, including without limitation, supplier and/or its affiliates. This License gives Client no ownership or similar rights with respect to any such content. Downloaded programs or information that is accessed by Client on or from WLT's Clients Only area of its Website is proprietary to WLT. Said information and programs are for Client's use only and fall under the same restrictions and guidelines for use and distribution as the Licensed Programs referenced herein.
The Licensed Programs and any associated copyright or other intellectual property rights of any nature whatsoever in or of the Licensed Programs are and shall remain the confidential, proprietary property and information of WLT. All report formats, programs, source code, manuals and any other material prepared by WLT and/or its agents under this Agreement relating to the Licensed Programs, shall solely and exclusively belong to WLT.

Client agrees to use all reasonable controls to protect the confidential nature of all Licensed Programs, manuals and related materials furnished by WLT, consistent with the manner in which it protects its own confidential business information, including but not limited to maintaining the Licensed Programs, manuals and related confidential materials in a secure manner and in an area only accessible to employees of Client who have need to use said Licensed Programs, manuals and related materials as covered in this Agreement

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SOFTWARE OF FLORIDA, INC.
INSURANCE SOFTWARE SPECIALISTS

for purpose of the Client's business. Client shall inform every such employee of the proprietary and confidential nature of said Licensed Programs, manuals and related materials.

I. EXPENSE REIMBURSEMENT

Client hereby agrees to reimburse WLT for all expenses over and above the agreed-upon cost for the Licensed Programs, incurred by WLT for supplies purchased or other expenses incurred by WLT for Client at the request of Client. All additional expenses must be approved in writing by Client, prior to the expense being incurred. Reimbursement of said expenses is payable within Thirty (30) Days of invoice from WLT.

J. TERMINATION

WLT shall have the right to terminate this Agreement and license granted herein as follows:

1. Upon Thirty (30) Days written notice in the event that Client, its officers, clients or employees violate any provision of this/their Agreement including, but not limited to, confidentiality and payment;

2. In the event Client's maintenance fees fall Sixty (60) Days past due or Client has no fully executed and current valid Maintenance Agreement with WLT;

3. In the event Client terminates or suspends business;

4. In the event Client becomes insolvent, makes an assignment for the benefit of a creditor, suffers or permits the appointment of a receiver, trustee in bankruptcy, or similar official for any substantial part of its business or assets;

5. In the event Client shall avail itself or become subject to any bankruptcy proceeding under federal bankruptcy codes or any statute or any procedure relating to insolvency or the protection of the rights of creditors;

6. In the event Client sells, trades, transfers, gives or in anyway relinquishes its business to other ownership or if ownership of Client's business changes in any way, and an addendum reflecting said change or a new Agreement has not been signed with WLT.

K. OBLIGATIONS OF TERMINATION

Upon any termination of this License Agreement for any reason, whether as a result of cessation of the use of the Licensed Programs, Client's default or otherwise, Client shall promptly deliver to WLT all magnetic tapes, diskettes, CDs or other media or tangible items and materials containing the Licensed Programs, manuals and related materials. Client shall also promptly return to WLT all copies thereof or destroy such copies and certify in writing to WLT that all copies have been returned or destroyed.

II. MISCELLANEOUS PROVISIONS

A. SEVERABILITY

The invalidity or unenforceability of any specific provision herein shall in no way affect the validity or enforceability of any other provision of this Agreement.

B. CAPTIONS

Titles and paragraph headings are inserted as a convenience and by way of reference only and in no way limit, enlarge, define or otherwise affect the scope or intent of, this Agreement or any provision hereof and are in no way to be construed as part of this Agreement.

C. THE ENTIRE AGREEMENT

It is mutually agreed that this Agreement and any exhibits attached, having been fully executed by the parties as referenced herein, represents the entire Agreement between the parties hereto with respect to the matters contained herein and that no agent, representative, manager, salesperson or officer of either of the parties hereto has authority to make, or has made, any statement, representation or agreement, oral or written, in connection herewith that is deemed, by either party, to be a part of this Agreement or that modifies, adds to, or changes this Agreement, unless it is attached herewith in an Addendum and signed as accepted by the authorized representatives of WLT and Client, and that **NO STATEMENT NOT CONTAINED IN THIS AGREEMENT SHALL BE BINDING UPON WLT AS A WARRANTY OR OTHERWISE.** The foregoing terms and conditions shall prevail notwithstanding any variance with the terms and conditions of any order submitted by Client with respect to equipment or software.

D. GOVERNING LAW

This Agreement shall be governed by the laws of the State of Florida, and any proceedings must be conducted in the State of Florida, in the County of Pinellas, or if in Federal Court, must be conducted in the State of Florida, in the City of Tampa. This entire Agreement shall survive any sale, merger or transfer of the business of either party and all terms and conditions set forth herein shall inure to the new owner or owners and they shall be bound by same as if they had personally signed this Agreement this date and Client's rights shall be no greater or lesser than WLT's rights under this Agreement.

E. WAIVER

Failure of either party to enforce compliance with any term or condition of this Agreement shall not constitute a waiver by the other party of such term or condition unless accompanied by a written statement that such term or condition is waived.

F. ASSIGNMENT

This Agreement shall be binding upon and inure to the benefit of the heirs, executors, administrators, successors and assigns of the parties, provided however, Client may not assign, sublicense or transfer any of its rights or duties under this Agreement without the prior written consent of WLT.

Client Initials WLT Initials TB Page 7

WLT SOFTWARE OF FLORIDA, INC.
INSURANCE SOFTWARE SPECIALISTS

G. NOTICES

Any notice to be delivered pursuant to this Agreement shall be deemed delivered upon service, if delivered personally, or Three (3) Days after deposit in the United States mail if mailed by first class mail, postage prepaid, registered or certified, and addressed to a party at the address set forth at the end of this Agreement or at such other address or to such other person as specified in writing prior to notice being duly given.

Client acknowledges that its representatives have read this entire Agreement and received a copy thereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement, affixed their signatures, and this Agreement shall become effective the date and year first written.

Accepted By Client:
CorrectCare, Inc.

By: _____
Signature

Arthur A Hellebusch
Type or Print Name

Title: President

Date: January 16 2006

Accepted By WLT:
WLT Software of Florida, Inc.

By: _____
Signature

Thomas P. Brooks
Type or Print Name

Title: **President**

Date: 1/23/06

Installation Site Name and Address:

CorrectCare, Inc.
366 South Broadway
Lexington, Kentucky 40508

****LICENSE VALID IF SIGNED BY JANUARY 31, 2006****

WLT Software of Florida, Inc. **Contract Number NCWIN-4104**

ATTACHMENT "A"

MEDICLAIMS FOR WINDOWS
RECOMMENDED HARDWARE SPECIFICATIONS

Please verify your hardware configuration with WLT prior to purchasing, as hardware configurations vary according to the size and needs of each organization. These recommendations are general and your actual requirements may vary widely according to your business practices.

SERVER
15 to 20 active users*

Hardware:
- Intel Xeon / 2 GHz (1 MB cache) CPU or better
- 2 GB of RAM or higher
- 1.44 MB floppy drive
- CD or DVD ROM drive
- Backup tape drive - DAT or DLT
- 17" SVGA monitor
- 100Mbps network interface
- Uninterruptible power supply
- Four 36 GB SCSI hard drives
- Internet connectivity or 56K modem

Software:
- Microsoft Windows 2003 or 2000 Server
- Oracle 10g** (8i and 9i are also supported)
- Backup software
- Symantec pcAnywhere Version 10.5
- Windows Remote Desktop

WORK STATIONS

Hardware:
- Intel Pentium 4 / 2 GHz CPU or better
- 100Mbps network interface
- 256 MB of RAM or higher
- 17" monitor

Software:
- Windows XP Pro (Windows 98 2nd Edition is also supported)
- MS Word 97 or later

Display Settings:
- The Display Properties screen area should be a minimum 800x600 pixels with font size of small fonts (normal size - 96 dpi) and Windows standard scheme.

NETWORK
- 100 Mbps connectivity throughout network, using switches to connect clients and servers.

PRINTERS
- Windows compatible laser printer for general purposes (e.g., reports).
- Appropriate Windows compatible printers for the type of checks desired; dot matrix for multi-part, or laser.

(If you will be using multi part forms, a high-speed line printer will be required to get reasonable performance.)

WLT systems use the following standard paper sizes:
- Checks: Laser 8½" x 11" (Continuous 9½" x 11")
- Reports: Laser 11"x 8½" (Continuous 12" x 8½")
- Letterhead: Laser 8½" x 11" (Continuous 9½" x 11")
- ID cards: Any size supported by MS Word as these are printed through a Mail Merge.
- Labels: Any size supported by MS Word as these are printed through a Mail Merge.

OPTIONAL FOR DATA INTEGRITY

Hardware:
- SCSI RAID Controller with onboard RAM
- More SCSI hard drives

* For more than 20 active users, Dual Xeon 3GHz (1 MB cache) processors and 4GB of RAM are recommended. If you have more than 50 active users, your requirements will be defined by your business needs, rather than the technical requirements of the WLT product. Please contact WLT to discuss these needs so we can assist in planning a solution that will support your business needs.

**** Oracle 10g version considerations:**
- *Standard Edition One* is the minimum and is sufficient for most WLT Clients (up to two CPUs).
- *Standard Edition* is required for more than two CPUs (up to four CPUs).
- *Enterprise Edition* should be considered for Data Guard, Partitioning, Advanced Security, servers with more than four CPU's, and multiple server configurations.

1/13/2006

Client Initials _____ WLT Initials _____ Page 9

SOFTWARE OF FLORIDA, INC.
INSURANCE SOFTWARE SPECIALISTS

3M SOFTWARE LICENSE AND SERVICES AGREEMENT

3M
Health Information Systems

SOFTWARE LICENSE AND SERVICES AGREEMENT
FOR
CONSULTANT AUDITING & CONTRACT CODING

THIS AGREEMENT is entered into and, effective as of the ***24th*** day of ***April, 2009,*** between 3M Company, together with its subsidiaries and affiliates, (collectively referred to herein as "3M") having an office at 575 West Murray Boulevard, Murray, Utah 84123-4611 and ***CorrectCare Integrated Health*** (hereinafter referred to "Customer") with offices at ***366 South Broadway, Lexington, KY 40508.***

Customer contracts for and 3M agrees to furnish the Software and related services described in this Agreement under the terms and conditions of this Agreement.

TERM OF THIS AGREEMENT: ***One (1) Year*** PAYMENT CYCLE: ***Annual***

CPU TYPE: ***Networking***

PRICING SUMMARY

SOFTWARE LICENSE FEES (Itemized on Software Schedule):	**$**	**6,188.00**
INSTALLATION & TRAINING FEES (Itemized on Software Schedule):	**$**	**N/A**
TOTAL SOFTWARE, INSTALLATION & TRAINING FEES:	**$**	**6,188.00**
DOWN PAYMENT AMOUNT:	**$**	**-0-**

This Pricing Summary does not include incidental expenses, such as freight, freight insurance, and reasonable travel expenses (excluding initial installation and training), which the contract indicates will be billed separately to Customer as they are incurred. It also does not reflect costs of services not obtained through 3M. If Customer elects a payment cycle more frequent than annual, applicable finance charges will apply. THE ABOVE PRICING IS CONTINGENT ON CUSTOMER'S ACCEPTANCE OF THE PROVISIONS IN THIS AGREEMENT WITHOUT MODIFICATION. 3M RESERVES THE RIGHT TO INCREASE PRICES IN THE EVENT CUSTOMER REQUIRES ANY PROVISION TO THIS AGREEMENT BE MODIFIED.

Customer has read this Agreement, each exhibit, including the disclaimers of warranties, limitations of liability and limitations of remedy, which are contained therein. To indicate their acceptance and agreement to be bound by the terms and conditions of this Agreement, 3M and Customer have executed this Agreement on the date(s) indicated below, to be effective as of the date first indicated above.

CORRECTCARE INTEGRATED HEALTH	3M COMPANY
BY X	BY
NAME X James Burkhardt	NAME Heather Bertotti
TITLE X COO	TITLE Contract Manager
DATE X 4/28/2009	DATE ***April 24, 2009***

ANY WRITTEN NOTICES UNDER THIS AGREEMENT SHALL BE SENT TO:

CorrectCare Integrated Health	3M HEALTH INFORMATION SYSTEMS 575 West Murray Boulevard Murray, UT 84123-4611
Attention: ***Brian Cundiff***	Attention: Contract Manager

Please Fax PO and Signed Contract to: (651) 732-7856

Issue Date: ***4/13/09*** Revision Date: ***4/24/09*** 3M Contract No: ***95229-09***

Site ID: ***2510479***
Batch: 95229

3M FORM SLA.CON.AUD.CON CODE.DOT v1.x

1.0 DEFINITIONS

1.1 "Authorized Site" means and includes any facility (such as hospitals, clinics, clinical laboratories, surgical centers or nursing homes) that control, is controlled by, is under common control with Customer, or is under a written management contract with Customer, that is specifically identified as an Authorized Site listed in Exhibit A to this Agreement. "Control" is defined as possessing fifty percent (50%) or more of the voting stock or other ownership interest. If Customer desires to have a facility included as an Authorized Site that does not otherwise meet the "Control" threshold set forth herein, 3M will consider the inclusion of such a facility on a case-by-case basis.

1.2 "Authorized Users" means the employees, contract workers (i.e., individuals employed by a third party assigned to perform, on a temporary basis, the same or similar functions of an Authorized Site's employees) and independent contractors (i.e., self-employed individuals who perform, on a temporary basis, the same or similar functions of an Authorized Site's employees) of an Authorized Site, an admitting physician (a licensed physician who has the privilege to admit patients at an Authorized Site) and a consulting physician (a licensed physician who provides medical consultation at an Authorized Site, or to an admitting physician). 3M will also permit Customer to include, as Authorized Users, consultants and contractors not otherwise included within the foregoing definition provided that (i) the consultant or contractor has a legitimate need to access and use the Software solely on behalf of an Authorized Site, (ii) the consultant or contractor is not, in 3M's reasonable opinion, a competitor of 3M and (iii) Customer requires such consultant or contractor to execute 3M's standard Third Party Access and Confidentiality Agreement. Authorized Users accessing Software (ASP) shall be issued passwords.

1.3 "Documents" means written reference, operations and/or users manuals and other documents, and all revisions thereto, which provide specifications for or instructions for the use of the Software and/or the implementation of the Services, and which are furnished to any Authorized Site by 3M.

1.4 "Equipment" means the central processing unit(s), any peripheral equipment and all interconnecting cables and wires physically located at the Installation Site(s) and/or Authorized Sites that meet or exceed 3M's then current minimum configuration requirements for using the Software, or substitute or backup equipment first approved by 3M in writing. The minimum configuration requirements for the Software (Customer Site Installed "CSI") and the Software (Application Services Provider "ASP") may be different.

1.5 "Installation Site" means the physical location to which 3M shall deliver the Software (CSI) for installation (i.e., "loading") on the Equipment or any substitute location first approved by 3M in writing. All Installation Sites shall be identified in Exhibit A to this Agreement.

1.6 "Services" means the services identified in Exhibit B, Part 2 Software and Services Schedule to this Agreement, as more particularly described in attachment A, Scope of Work. Services do not include 3M's implementation of the Software (Section 2.2), training provided to Authorized Users (Section 2.3) or Software Support Services (Section 3).

1.7 "Software" means 3M Software and Third Party Content. Provisions of this Agreement referring to Software denoted as "CSI" shall apply only to Software that is implemented by delivery of the Software to the Customer, on physical media or by online download, for installation on the Equipment. References in this Agreement to Software denoted as "ASP" shall apply only to Software that is implemented by enabling the Customer to access and use the functionality of the Software, or the results produced by the use of the Software, remotely via the Internet, Virtual Private Network or other online means without installation of the Software on the Equipment. Provisions of this Agreement referring to Software without denotation to "CSI" or "ASP" shall apply to both types of Software.

1.8 "3M Software" means all copies of 3M-owned computer program(s) identified in Exhibit B, Part 1, Software Schedule to this Agreement and any Updates thereto.

1.9 "Software Implementation Date" means, with respect to: (i) any particular Software (CSI), the earliest date on which the Software (CSI) is installed (i.e., "loaded") on the Equipment and passes 3M's diagnostic tests for such Software (CSI), or (ii) is put into use by Customer for any purpose other than for testing purposes that takes place before 3M begins its diagnostic tests, whichever occurs first. Customer-installed Software (CSI), if any, will be presumed to be loaded on the Equipment seven (7) days after shipment by 3M, and (ii) any particular Software (ASP), the earliest date on which an Authorized User is permitted to access the Software (ASP).

1.10 "Term" means the period of time during which this Agreement remains in effect, beginning with the Initial Term and continuing throughout each successive Renewal Term, if any. The "Initial Term" of this Agreement is the period of time set forth on the face of this Agreement commencing on the earliest Software Implementation Date. A "Renewal Term" is the additional period of time that this Agreement remains in effect, pursuant to Section 9.2, following the end of the Initial Term, or an immediately prior Renewal Term.

1.11 "Third Party Content" means all non-3M-owned computer programs and/or materials (including, but not limited to, for example, CPT™ codes) incorporated into, or distributed by 3M for use in conjunction with, 3M Software, together with any Updates or diagnostic support aids thereto which are distributed to any Authorized Site by 3M.

1.12 "Update" means an enhancement or modification to the Software which 3M makes generally available to its customers without an additional or increased license fee.

2.0 SOFTWARE AND SERVICES

2.1 **Ownership.** Title to all copies of the Software and Documents (including those made by Authorized Users), and to all 3M confidential and proprietary information, shall be and remain vested in 3M and/or its suppliers. 3M also retains title to all media used to supply Software to Customer. Title to the software or other analytical tools that 3M utilizes to provide Services under this Agreement ("Service Tools") shall be and remain vested in 3M and/or its suppliers. No license, express or implied, under any patents, copyrights, trademarks or other property rights to such Service Tools are granted to Customer under this Agreement unless such Service Tools are specifically set forth in Exhibit B, Part 1.

2.2 **Implementation.**

2.2.1 **Software (CSI) Installation.** Software (CSI) must be installed on Customer's Equipment at the designated Installation Site(s). Software shall be installed by 3M; however, certain Software (CSI) may be identified in Exhibit B as Customer-installable ("CI"). Customer shall, at its expense, be responsible to see that all Customer-installable Software (CSI) is installed and placed in working order. Customer shall provide 3M with all relevant specifications and other documents and shall supply all cables, interface hardware and other Equipment reasonably required to integrate and interface the Software (CSI) with Customer's instruments and other computer systems.

2.2.2 **Software (ASP) Implementation.** means, for purposes of this Agreement, the initial configuration of the database application and establishment of the database and reporting format, if any, establishment of the number of users and user identities, and completion of software download and system build, if any, and delivery of password. Customer shall maintain proper Equipment, instruments and computer systems reasonably necessary to allow Customer to access the 3M ASP Software. Customer's Implementation Plan is attached hereto as Exhibit F.

2.3 **Training.** 3M shall train Authorized Users in use of the 3M Software. The number of Authorized Users to be trained shall be listed on Exhibit B. Training, if any, shall be provided at Customer's location, or remotely via phone, video or Internet conferencing. Customer shall, at its expense: (i) provide the necessary Authorized Users for training at the scheduled times and training locations, and (ii) provide the necessary training resources including, but not limited to, rooms, overhead projectors, video equipment and personal computers for computer based training. Customer shall provide adequate time for training of Authorized Users, as defined by 3M's installation and training personnel.

2.4 **Software License.** **During the Term of this Agreement, 3M grants Customer a nontransferable, nonexclusive license ("License") to permit Authorized Users to access and use the Software and Documents solely for purposes of providing Auditing and/or Contract Coding Services to Customer's clients** with whom Customer has entered into a contract for such Auditing and/or Contract Coding Services solely on Customer's designated Equipment at the Authorized Site(s) listed on Exhibit A and/or by Authorized Users located within the U.S. and conditioned upon Customer's payment of the Software License Fees set forth in Exhibit B, or Exhibit B-1, as applicable. Customer may provide Auditing and/or Contract Coding Services to Customer's clients without the payment by Customer of additional license fees provided that Customer references the use of the 3M Software in reports to Customer's clients. In the event Customer provides Contract Coding Services to its clients, such contract Coding is limited to temporary coding services, not to exceed (i) sixty (60) consecutive days and (ii) fifty percent (50%) of any Customer's client's annual data over a twelve (12) month period. **Outsource Coding is expressly prohibited under this Agreement under any circumstance.** The License granted to Customer does not permit Customer to do or permit any of the following without 3M's prior written consent: (i) make extra copies of the Software or Documents (except for the limited purposes set forth below), (ii) sublicense, lease, lend, transfer or permit access to the Software or Documents (or any copies thereof) to any third party, (iii) permit access to, or the use, of the Software or Documents by any person, facility or entity that is not an Authorized User, (iv) use, or permit the use of, the Software or Documents to process transactions of any entity or facility that has not been specifically reported as a Customer client in a quarterly report as required under Section 8.6 of this Agreement, or (v) disassemble, reverse-engineer or create derivative works based upon the Software. Customer is solely responsible for informing and ensuring that all Authorized Users permitted to access and use the Software or Documents (including all Authorized Users who access and use the Software or Documents from remote locations), comply with the restrictions of Sections 2.4, 2.5 and 4. Notwithstanding the foregoing, Customer may make such copies of the Software and/or Documents as are necessary to secure the Customer's data or which are essential to the operation of the Equipment. During any period of Equipment malfunction causing the Software to be inoperative, Customer may use the Software on other Equipment; however, Customer shall not remove the Software from the Installation Site without 3M's written consent, which shall not be unreasonably withheld. Upon thirty (30) days advance notice, at Customer's regular business hours, Customer shall allow 3M, or a third party designated by 3M, to inspect and audit Customer's books, records and use of the Software and Documents solely and exclusively for the purpose of verifying Customer's compliance with its obligations under this Agreement. Any audit shall be paid for by 3M; provided, however, that Customer shall pay for the expense of the audit if the audit reveals a violation of the Agreement. For purposes of this Agreement:

a. "Auditing" means to review Customer's client's previously coded data using the Software and provide to Customer's client's Reports regarding such review. For purposes of this Agreement, "Reports" means documents, produced by Customer in either electronic or hard-copy, printed format, and provided to Customer's clients containing a compilation and/or analysis of auditing performed on such Customer's client's data. Customer shall include on all Reports the following notice whether such Reports are made available to Customer's clients in either electronic or hard-copy format: "This Report was produced using proprietary computer software

created, owned and licensed by the 3M Company. All copyrights in and to the 3M™ Software (including the selection, coordination and arrangement of all codes) are owned by 3M. All rights reserved."

b. "Contract Coding" means an agreement between Customer and Customer's client for Customer to assist its client in temporary coding not to exceed sixty (60) consecutive days or fifty percent (50%) of any Customer's client's data over a twelve (12) month period, for such purposes as coverage for vacation and sick leave, open position, work overload relief and backlog coding. Any use of the Software to Contract Code, which extends beyond sixty (60) consecutive days or exceeds fifty percent (50%) of a client's data shall be deemed to be Outsource Coding. **Outsource Coding is expressly prohibited under this Agreement under any circumstance.**

c. "Outsource Coding" means a long-term agreement between Customer and a Customer's client under which Customer takes responsibility for the coding of a substantial amount of Customer's client's inpatient and /or outpatient medical records or coding for coverage purposes that exceeds sixty (60) consecutive days.

2.5 **Third Party Content.** Except as otherwise indicated in this Agreement, all terms and conditions of this Agreement, including the applicable terms and conditions set forth in Exhibit D, if any, shall apply to Third Party Content. 3M reserves the right to add or delete Third Party Content and to revise the provisions of Exhibit D in the event that the licensor of any Third Party Content requires 3M to pass through modified terms and conditions applicable to its Content. In the event of a conflict between the terms and conditions of this Agreement and those set forth in Exhibit D with respect to Third Party Content, the terms and conditions of Exhibit D shall control. If 3M provides Third Party Content to Customer that is accompanied by its own license agreement (e.g., "shrink-wrap" or "click wrap" terms and conditions) such Third Party Content license agreement shall control Customer's use of the Third Party Content. In the event Customer is permitted by a Third Party Content license agreement to change, modify or make any derivative work from the Third Party Content; Customer assumes total responsibility for any resulting Equipment and/or Software malfunctions.

2.6 **Remote Coding.** Customer is responsible for ensuring that all access to and use of the Software (CSI) by Authorized Users from remote locations ("Remote Coding") is in accordance with terms and conditions of this Agreement including, but not limited to, the use of the Software (CSI) solely for the benefit of the Authorized Sites listed in this Agreement. Security to detect and/or prevent unauthorized access, disclosure or use of protected health information ("PHI") or Customer's Operational Information (as defined in Section 4.2.2) data is the sole responsibility of Customer, and Customer agrees to indemnify and hold 3M harmless from any demands, claims, or suits by a third party for loss, judgment, damages or expenses (including attorney's fees) arising out of or related to unauthorized access, disclosure or use of PHI or Customer's Operational Information in Remote Coding situations.

2.7 **Software Security.** 3M provides limited utilities and functions as part of the Software to limit access to the Software to authorized personnel. The overall effectiveness of software security depends upon the Customer's proper use of the 3M utilities and functions, and Customer's own policies, procedures and software/hardware security devices. Accordingly, so long as the Software meets the performance warranty set forth in Section 6.3, Customer agrees to indemnify and hold 3M harmless from any demands, claims, or suits by a third party for loss, judgment, damages or expenses (including attorney's fees) arising out of or related to unauthorized access to the Software (CSI) or unauthorized access of Software (ASP) through the use of a Password by an individual other than the Authorized User to whom the Password was assigned.

2.8 **Password Security.** Customer is responsible for the security of all passwords provided to Customer and its Authorized Users by 3M for access to and use of the Software under this Agreement. In the event that access to, or use of, a Customer's password is permitted by Customer, or gained by an unauthorized party while such password is in the possession of Customer, and subsequently access to, or use of the Software is made by such unauthorized party, Customer shall be solely responsible for any access to, or use of, the Software, or activity or transaction using the Software by such unauthorized party. Customer understands and agrees that the access to, or use of, the Software by any person using a password provided to Customer or its Authorized Users constitutes an authorization by Customer to use such password and access or use the Software, without limitation. Customer shall be solely liable for all access to, or use of, the Software using the Customer's passwords, until 3M has received notification from Customer in writing that the security of such password, and subsequent access or use, is not authorized. Customer agrees to immediately notify 3M of any possession, or use, of its passwords by an unauthorized party of which it becomes aware. Upon such notification, 3M shall terminate such password and issue a new password to Customer.

2.9 **Customer's Responsibilities.**

2.9.1 **Software Operating Results.** While 3M makes the Software available for Customer's use, Customer understands and acknowledges that it is solely responsible for the use it makes of the Software including, but not limited to, monitoring and verifying the input to and output from the Software. Accordingly, so long as the Software meets the performance warranty set forth in Section 6.3, Customer agrees to indemnify and hold 3M harmless from any demands, claims, or suits by a third party for loss, judgment, damages or expenses (including attorney's fees) arising out of or related to Customer's use of the Software by Customer or any other person.

2.9.2 **Services.** 3M's performance of Services, and the timeliness of that performance, depends upon Customer's cooperation and support. 3M's time of performance, if fixed, shall be enlarged to the extent reasonably necessary, in the event that: (a) Customer fails to submit data in the prescribed form or as required by this Agreement, or as necessitated for 3M to complete Services which may become part of this Agreement, (b) any force majeure occurrence including, acts of God,

malfunction of any equipment or other cause beyond the control of 3M, (c) special requests by Customer or any governmental agency or other regulatory authority authorized to regulate or supervise Customer that impact 3M's performance of the Services; or (d) if Customer fails to provide any equipment, software, premises, performance or other assistance called for or necessitated by this Agreement. Customer understands and acknowledges that it is solely responsible for, the use the Customer makes of any advice, recommendations, information or data, including evaluations and advice relating to the performance or effectiveness of certain personnel employed by or under contract with Customer (collectively, "Work Product") that 3M supplies to Customer resulting from Services performed under this Agreement. In addition, except for intellectual property infringement, 3M shall have no liability for and Customer agrees to indemnify and hold 3M harmless from any third party demands, claims, or suits by any party for loss, judgment, damages or expenses (including attorney's fees) arising out of or related to use the Customer makes of the Work Product by Customer or any other person.

3.0 SUPPORT SERVICES

3.1 **Scope of Support Services.** Beginning on the Software Implementation Date and continuing throughout the Term of this Agreement, 3M shall provide Customer with the following support services ("Support Services") at no additional charge provided that the Software in use by Customer is the most current or the immediately preceding Update level:

3.1.1 **Corrections.** 3M shall correct significant deviations between the 3M Software and the applicable Documents and any incompatibility between the 3M Software (CSI) and the operating system software of any Equipment, which has been approved by 3M for use with 3M Software.

3.1.2 **Updates.** 3M shall provide Updates to the 3M Software. 3M will use commercially reasonable efforts to provide Updates to meet the requirements of federal laws and regulations (including, for example, changes to DRG, APC, ICD-9, and CPT™ codes); provided, however, where changes in laws and regulations (including, for example, implementation of ICD-10) are, in 3M's reasonable determination, significant enough to require the development of new software products or new features and/or functions for existing software products, then: (i) 3M may, but is not required to develop the new features, functions and/or software products, and (ii) 3M may charge additional license and support fees in connection with any additional features, functions and/or software products it chooses to develop. Updates for Software (CSI) are designed to be Customer-installable. When on-site support for Updates is requested by Customer, 3M reserves the right to charge Customer 3M's then-current fees for installation and training in connection with Updates which require 3M personnel to provide support at Customer's site. Such charges are not included in the fees listed on the face of this Agreement. 3M will use reasonable efforts to notify Customer of additional charges and/or Equipment necessary to make an Update operational prior to the release of such Update.

3.1.3 **Telephone Support.** 3M shall provide Customer with telephone assistance to support Customer's use of the3M Software. Telephone Support will be available during the hours of 6:00 a.m. to 5:00 p.m. MST/MDT Monday through Friday, excluding normal business holidays. A detailed explanation of Support Services can be found in the Document, Customer Support Guide. Support for a Priority 1 problem (defined as a problem which is stopping production or adversely affecting patient care, and for which there is no alternative way to operate the system) will also be provided outside such hours 365 days per year. If, at any time, Customer experiences a Priority 1 problem with 3M Software, 3M shall provide Support Services within four (4) hours after Customer has notified the designated 3M support center.

3.1.4 **ICD-10 Version of the Software.** When federal law and/or implementing regulations require the use and/or submission of data based upon the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, published by the World Health Organization ("ICD-10"), 3M shall provide to its then-current Customers the following Updates: (i) for Customers licensing the ICD-9 version of the 3M Coding and Reimbursement Software and 3M Grouping Software, 3M will provide an Update that replaces the ICD-9 version with an ICD-10 compliant version of the 3M Software, (ii) for Customers licensing the 3M Interface Software (CSI), 3M will provide an Update that will allow the transmission of ICD-10 data, and (iii) for Customers licensing 3M Software (CSI) containing a database, 3M will provide an Update that will accommodate storage and transmission of ICD-10 data. Fees for these Updates will be based upon Customer's then-current Agreement. 3M will increase license fees the maximum amount in Section 8.1.b. of the Agreement in both the year immediately preceding the year in which federal law requires the use and/or submission of ICD-10 based data, and in the year in which federal law requires the use and/or submission of ICD-10 based data (for example, if federal law requires the use and/or submission of data based upon ICD-10 beginning on October 1, 2010, a 3M customer subject to a maximum annual license fee increase of five percent (5%) will receive a five percent (5%) license fee increase during the period between October 1, 2009 and September 30, 2010, and the period between October 1, 2010 and September 30, 2011 such increase to be included on Customer's annual invoice. If 3M develops and commercially releases other software products or services related to ICD-10, Customer may elect to acquire such additional ICD-10 products and/or services at 3M's then-current prices. Customer shall be responsible for any associated installation and/or training requested from 3M. 3M may also charge additional Support Service fees related to new software products. 3M will permit Customers to simultaneously access and use their ICD-9 version of the 3M Software at no additional license charge for a period not to exceed months (3) months from the installation of the ICD-10 Update to the Software to permit the coding of those records that require reporting under the ICD-9 regulations. Thereafter, Customer's license for the ICD-9 version of the 3M Software shall terminate. If Customer desires to use the ICD-9 version of the 3M Software longer than provided for herein, Customer must enter into a license agreement for such 3M Software at the then-current license fees.

3.2 **Customer's Obligations.** To enable 3M to provide Support Services under this Agreement, Customer shall: (i) notify 3M when support is required and report problems to 3M, (ii) allow 3M reasonable access to Customer's system and the reasonable use of necessary site facilities, utilities, data communications and system resources with ready access at no charge, (iii) when requested by 3M, collect data and other information necessary for 3M to resolve system problems, (iv) maintain the database and program libraries as specified by 3M, (v) obtain any additional Equipment, updates to third party application software and third party operating system Software (as reasonably specified by 3M) necessary to make an Update operational, (vi) provide time for installation of all Updates (CSI), (vii) perform regular daily backups, and (viii) provide qualified personnel to work with 3M personnel.

3.3 **Modification of Support Services.** After the Initial Term of this Agreement (as set forth on the face of this Agreement), 3M may modify the Support Services offered with respect to the Software by giving Customer written notice ninety (90) days prior to any renewal date, including the first renewal date.

4.0 CONFIDENTIAL INFORMATION, TRADENAMES AND COPYRIGHTS

4.1 **Customer's Obligations.** Customer acknowledges that this Agreement, the Software, the Documents and the Passwords (where applicable) constitute and/or contain information that is confidential to and proprietary trade secrets of 3M and/or its suppliers ("3M Information"). Customer agrees to treat all 3M Information as confidential, to require all Authorized Users who Customer permits access to the Software or the Documents pursuant to Section 2.0 to comply with this Section 4.1, and otherwise use its best efforts to prevent unauthorized disclosure of 3M Information. The obligations of this Section 4.1 shall not apply to any 3M Information, which is public information on the date this Agreement is completely executed, or becomes public information subsequent to such date through acts not attributable to Customer. The existence of a copyright notice shall not cause or be construed to cause the Software or the Documents to be a published copyrighted work or to be public information or in the public domain. Customer shall not remove the trademarks, trade names or any notice of 3M or 3M's suppliers from any Equipment, Software, Documents or other materials delivered to Customer pursuant to this Agreement, and will cause them to appear on all copies made by Customer pursuant to Section 2.0.

4.2 **3M's Obligations.** 3M acknowledges that in the course of performing this Agreement it may be given access to information that is confidential to Customer or to third parties, including Customer's patients. 3M agrees to treat all such information as confidential in accordance with the following provisions:

4.2.1 **Protected Health Information ('PHI').** To the extent required by the Health Insurance Portability and Accountability Act of 1996, or "HIPAA," and the regulations promulgated there under, the parties shall abide by the terms of Exhibit C, Business Associate Addendum.

4.2.2 **Operational Information.** In addition, 3M agrees to treat all Customer Information other than PHI including, but not limited to, hospital and medical systems, financial and billing data and other operational information (collectively, "Operational Information") as confidential and to use its best efforts to prevent unauthorized disclosure of such items by 3M's employees, agents, representatives and contractors. The obligations of this Section 4.2.2 shall not apply to any Operational Information which is public information on the date this Agreement is completely executed, or becomes public information subsequent to such date through acts not attributable to 3M or its employees, agents, representatives or subcontractors.

5.0 ACCESS TO 3M BOOKS AND RECORDS

5.1 **Access.** To the extent required by applicable law (42 U.S.C. 1395x(v) (1) (I) and 42 CFR Sec. 420.300 through 420.304, or any successor statutes or regulations), until the expiration of four (4) years after the furnishing of services under this Agreement, 3M shall make available upon written request to the Secretary of Health and Human Services ("Secretary") or the Comptroller General, or to any of their duly authorized representatives, this Agreement and such books, documents and records of 3M that are necessary to verify or certify the nature and extent of 3M's invoiced charges for services furnished to Customer.

5.2 **Subcontracts with Related Organizations.** 3M agrees that to the extent required by applicable law, if 3M carries out any of its duties under this Agreement through a subcontract with a related organization with a value or cost of $10,000 or more over a twelve month period, that subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of services under that subcontract, the related organization will make available, upon written request to the Secretary, or to the Comptroller General, or to any of their duly authorized representatives, the subcontract and such books, documents and records of the related organization that are necessary to verify or certify the nature and extent of the costs incurred by Customer based on 3M's invoiced charges for services furnished by the related organization.

6.0 WARRANTIES AND REPRESENTATIONS

6.1 **Authority.** 3M represents and warrants to Customer that, during the Initial Term of this Agreement and any renewal thereof, it has and will have full power and authority to enter into this Agreement and perform hereunder; and that such entry and performance does not and will not violate any rights of any third party.

6.2 **Non-infringement.** 3M further represents and warrants to Customer that, during the Initial Term of this Agreement and any renewal thereof, the 3M Software and Documents do not infringe any patent, copyright, trademark or trade secret rights of any

third party. Customer shall immediately notify 3M of any infringement claim and provide 3M with a copy of any pleadings. The selection of counsel, the conduct of the defense of any lawsuit and any settlement shall be within the sole control of 3M, and at 3M's expense. 3M also agrees to indemnify and hold Customer harmless from any damages or expenses (including attorney's fees) actually and finally awarded against Customer in any lawsuit arising out of or related to 3M's alleged infringement of a third party's intellectual property rights. 3M may, at its option and expense, procure for Customer the right to continue using the allegedly infringing 3M Software, replace it with a non-infringing item, modify it so it becomes non-infringing, or require Customer to return all copies of the allegedly infringing 3M Software to 3M and grant Customer a pro rata credit for the unused portion of the prepaid Software license fee for the current year and terminate the applicable Support Services. THIS SECTION 6.2 STATES THE SOLE AND EXCLUSIVE REMEDY OF CUSTOMER FOR ANY ALLEGED INFRINGEMENT AND IS IN LIEU OF ALL WARRANTIES, EXPRESS OR IMPLIED, IN REGARD THERETO. This warranty does not extend to any Third Party Content.

6.3 **Performance Warranties.**

6.3.1 **3M Software.** 3M represents and warrants that, so long as Customer has licensed the 3M Software from 3M

on a continuous and uninterrupted basis from the Software Implementation Date and, where applicable, has installed and is using the then-current or immediately preceding 3M Software (CSI) Update level, the 3M Software shall perform in substantial accordance with the Documents; however, 3M does not represent or warrant that the operation of the 3M Software will be uninterrupted or error-free. Upon receipt of written notice from Customer that 3M Software fails to meet this warranty, 3M shall provide the Support Services set forth in Section 3.0 of this Agreement. In the event 3M is unable to remedy a breach of warranty in this Section 6.3, Customer shall return all copies of the applicable 3M Software to 3M and 3M shall grant Customer a pro rata credit for the unused portion of the prepaid Software license fee for the current year and terminate the applicable Support Services. This warranty does not extend to any Third Party Content.

6.3.2 **Services.** 3M warrants to Customer that the Services will be performed in a good and workmanlike manner. In the event of a breach of the foregoing warranty, 3M's exclusive liability, and Customer's exclusive remedy, shall be for 3M, at its option, to either: (i) re-perform the Services in a manner consistent with this warranty, or (ii) refund to Customer any amounts paid for the Services that fail to meet this warranty and terminate this Agreement without further obligation on the part of either party. The warranty set forth in this Section 6.3.2 constitutes the sole and exclusive remedy provided by 3M with respect to the Services, and such warranty and remedy are in lieu of all other warranties and remedies.

6.3.3 **Warranty Exclusions.** The warranties set forth in this Agreement do not apply if: (a) the Software is used, in whole or in part, with computer equipment, interfacing or other software other than those recommended in writing by 3M for use with the Software; (b) Customer or anyone other than 3M or its employees in any way maintains, attempts to maintain, modifies or attempts to modify the Software or any part thereof in any manner other than as specified in the Documents, except for those elements of the Software that are specified in the Documents as being user-definable; (c) Customer uses or allows the Software to be used in any manner other than as specified in the Documents; (d) Customer fails to use any new or corrected versions of the Software or any component thereof made available by 3M; (e) Customer fails to follow any written directions or to perform any procedures prescribed by 3M in writing; (f) any abuse, misuse, accident or negligence, in each case other than by 3M or 3M's contractors shall have occurred in relation to the Software; or (g) the non-conformance shall have been caused other than by the Software, 3M or 3M's contractors. If the origin of a problem is determined to be other than non-conformance of the 3M Software or Services to the applicable warranty, and if 3M agrees to provide Customer with Services to further identify and/or remediate the cause of the problem, Customer will pay 3M, for all resources expended in addressing the claim, on a time and materials basis at 3M's then current rates, plus any associated travel, lodging and sustenance expenses actually incurred in accordance with 3M's travel expense policy.

6.4 **Disclaimer.** EXCEPT FOR THE REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS SECTION 6, 3M AND ITS SUPPLIERS DISCLAIM ANY AND ALL WARRANTIES, WHETHER EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE AND THOSE ARISING FROM TRADE USAGE OR COURSE OF DEALING.

7.0 LIMITATION OF LIABILITY

7.1 **Lost Data or Information.** IT IS EXPECTED THAT CUSTOMER WILL PERFORM ROUTINE BACKUPS OF ITS INFORMATION PRIOR TO USING THE SOFTWARE TO PROCESS OR ANALYZE THAT INFORMATION. ACCORDINGLY, 3M AND ITS SUPPLIERS SHALL NOT BE LIABLE TO CUSTOMER FOR ANY LOSS OR DAMAGE RESULTING FROM LOST DATA OR INFORMATION. IN THE EVENT DATA OR INFORMATION IS LOST DUE TO ANY NEGLIGENT ACT OR OMISSION BY 3M OR DUE TO BREACH OF ANY WARRANTY, 3M'S SOLE LIABILITY AND CUSTOMER'S SOLE REMEDY SHALL BE FOR 3M TO USE ITS BEST EFFORTS TO RECOVER THE LOST DATA OR INFORMATION AT NO CHARGE TO CUSTOMER.

7.2 **Excluded Damages.** NEITHER 3M AND ITS SUPPLIERS, NOR CUSTOMER SHALL BE LIABLE TO THE OTHER UNDER ANY CIRCUMSTANCES FOR ANY INCIDENTAL, SPECIAL OR CONSEQUENTIAL DAMAGES OR ECONOMIC LOSS, BASED UPON BREACH OF WARRANTY, BREACH OF CONTRACT, NEGLIGENCE, STRICT LIABILITY IN

TORT OR ANY OTHER LEGAL THEORY EVEN IF 3M OR ITS SUPPLIERS OR CUSTOMER HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOSS OF PROFITS, REVENUE (EXCEPT FOR LOSS OF PROFITS OR REVENUE TO 3M ARISING FROM CUSTOMER'S FAILURE TO PAY AMOUNTS DUE UNDER THIS AGREEMENT OR CUSTOMER'S BREACH OF SECTION 2.4 or 2.5), EQUIPMENT USE, DATA OR INFORMATION OF ANY KIND.

7.3 **Maximum Liability.** 3M'S MAXIMUM CUMULATIVE LIABILITY FOR: (i) ALL DAMAGES, COSTS OR EXPENSES OF ANY TYPE OR NATURE RECOVERABLE UNDER LAW OR CONTRACT ARISING OUT OF OR RELATING TO SOFTWARE LICENSED UNDER THIS AGREEMENT IS LIMITED TO THE SUM OF THE SOFTWARE LICENSE FEES ACTUALLY PAID TO 3M BY CUSTOMER FOR THE INITIAL TERM OF THIS AGREEMENT FOR THE SOFTWARE THAT GIVES RISE TO THE LIABILITY, OR ONE MILLION DOLLARS ($1,000,000), WHICHEVER IS LESS, AND (ii) FOR ALL DAMAGES, COSTS OR EXPENSES OF ANY TYPE OR NATURE RECOVERABLE UNDER LAW OR CONTRACT ARISING OUT OF OR RELATING TO SERVICES PURCHASED UNDER THIS AGREEMENT IS LIMITED TO THE AMOUNT OF THE FEES ACTUALLY PAID TO 3M FOR THE SERVICES PERFORMED THAT GIVE RISE TO THE LIABILITY.

7.4 **Essential Elements.** The warranty disclaimer and the limitation of liability provisions set forth in this Agreement reflect an informed, voluntary allocation of risk between the parties, and constitute essential elements of the bargain between them. 3M would not have made the Software and/or Services available to Customer at the prices set forth in this Agreement if it did not include such provisions.

8.0 FEES, INVOICING AND PAYMENTS

8.1 **Software.** License fees for each item of Software are set forth in the Software Schedule and shall be invoiced to Customer as set forth below. If applicable, Customer shall, upon execution of this Agreement, pay 3M the down payment set forth on the face of this Agreement, and the down-payment shall appear on the initial invoice(s) as a credit against the first year license fees. Notwithstanding anything to the contrary contained in any Third Party Software license agreement, Customer shall pay all license fees to 3M with respect to Third Party Software as provided in this Agreement for the Term of this Agreement.

a. **First Year of the Initial Term.** License fees for the first year, set forth in the Software Schedule and summarized on the face of this Agreement, will be invoiced to Customer on or shortly after the Software Implementation Date; provided, however, that if Customer delays or postpones the Software Implementation Date for more than thirty (30) days beyond the scheduled Software Implementation Date for any reason other than 3M's breach of this Agreement, 3M will invoice Customer the remaining unpaid balance of License fees for the first year.

b. **Second and Subsequent Years of the Initial Term.** Subject to the provisions of Section 8.1(d) below, Software license fees for the second and subsequent years of the Initial Term shall be communicated to the Customer by e-mail, U.S. mail, or courier at least sixty (60) days prior to the anniversary of the Software Implementation Date and shall be due on the Software Implementation Date. Total license fee increases, if any, in the second and subsequent years of the Initial Term shall not exceed five percent (5%) of the license fee for the immediately preceding year unless otherwise indicated on the Software Schedule.

c. **Additional Software and/or Authorized Sites.** During the Initial Term or any Renewal Term of this Agreement, the parties, upon mutual consent, may add new items of Software or additional Authorized Sites to this Agreement. For the administrative convenience of the parties, 3M shall prorate the first year's license fees for the new Software and/or Authorized Sites to the next anniversary of the Software Implementation Date of this Agreement. Thereafter, 3M will submit a single invoice for the annual license fees for all Software. The license term for all items of Software shall then co-terminate with the license Term provided for the item of Software having the earliest calendar Software Implementation Date.

d. **Renewal after the Initial Term.** License fees for years after the Initial Term for which this Agreement is renewed shall be at 3M's then-current license fee less any applicable discount, which shall be communicated to the Customer at least ninety (90) days prior to the end of the Initial Term and the end of any yearly renewal period hereof.

8.2 **Software Installation and Training.** Charges for Software implementation and training are set forth in the Software and Services Schedule and shall be invoiced on or after Software Implementation Date. If Customer cancels an agreed upon implementation and/or training date less than seven (7) days prior to such date, or if Customer is unprepared to go forward with implementation and/or training on the agreed upon installation and/or training date, then 3M may invoice Customer for any non-refundable travel-related costs and expenses and one day's installation and/or training (as applicable) at 3M's then current rate.

8.3 **Services.** Charges for Services are set forth in the Software and Services Schedule, and shall be invoiced as set forth therein. As a matter of convenience for the parties, Services with annually recurring fees shall be invoiced in the second and subsequent years on the same invoice with the Software license fees. Travel and related expenses shall be invoiced after such expenses have been incurred.

8.4 **Miscellaneous Charges.** All charges and fees not specified in this Agreement shall be invoiced to Customer shortly after such charges or fees accrue. Customer shall have the right to approve all miscellaneous charges before they are incurred on behalf of Customer.

8.5 **Invoicing, Payments.** All charges and fees under this Agreement are due and payable in full in U.S. dollars within thirty (30) days after the date of invoice (the "Payment Period"). If Customer disputes an item and/or amount on an invoice for which it intends to withhold payment, it must, during the Payment Period: (i) give 3M a written notice detailing the basis of the dispute (or the invoice shall be deemed undisputed), and (ii) pay all undisputed amounts in full within the Payment Period. 3M may assess a late payment charge on all undisputed amounts at the rate of one percent (1%) per month or the maximum rate permitted by applicable law, whichever is less, on the unpaid amount for each month (or fraction of a month) any payment is late. If Customer becomes thirty days past due with respect to any undisputed amounts due on an invoice, 3M may, upon written notice to Customer, immediately suspend the provision of Services set forth in Section 2.0 and/or the Support Services set forth in Section 3.0 until such past due charges are brought current or until this Agreement is terminated for breach as set forth in Section 9.2. Except as specifically set forth in Section 9.2, all amounts paid by Customer to 3M under this Agreement are non-refundable.

8.6 **Invoicing Services.** As a matter of convenience for the parties, Services shall be invoiced in conjunction with the related Software. Those services with annual fees shall be prorated to the next Software Installation Date on the first year's invoice. Those services with annual fees shall be invoiced in the second and subsequent years on the same invoice with the Software license fees.

8.7 **Taxes.** In addition to the charges and fees specified herein, Customer shall pay or reimburse 3M for all taxes, customs duties and amounts levied instead of taxes resulting from this Agreement, except for personal property taxes on the Software and taxes based on 3M's net income. If Customer is exempt from any taxes, Customer shall certify such exemption in a form satisfactory to 3M.

8.6 **Statement, Audit.** Customer shall provide to 3M a statement within thirty (30) days of the end of each calendar quarter (ending March 31, June 30, September 30 and December 31) during the term of the Agreement which identifies: (i) the name and address of each Customer client receiving Auditing or Contract Coding Services, (ii) the date on which the agreement under which Customer provides Auditing or Contract Coding Services to such Customer's client was executed, (iii) a cumulative total of the percentage of each Customer client's annual data which Customer has processed year-to-date for each such Customer client, (iv) the number of Authorized Users having access to and/or use of the 3M Software, and (v) a calculation of the Customer Client Fees due to 3M with sufficient detail to verify such calculation. Such statement shall be delivered to 3M electronically using the form attached hereto as Exhibit E at 3mhisreporting@mmm.com even if no quarterly payment is due. Customer shall maintain books and records substantiating its payments to 3M hereunder and make such books and records available to 3M upon request and in accordance with Section 2.4 of this Agreement.

9.0 TERM, NONRENEWAL AND TERMINATION

9.1 **Term.** This Agreement shall become effective upon complete execution by the parties and shall remain in effect for the period of time set forth on the face of this Agreement ("Initial Term") commencing on the earliest Software Implementation Date. Thereafter, this Agreement shall automatically renew for successive one (1) year terms (each a "Renewal Term") unless either party gives the other party written notice at least sixty (60) days prior to the expiration of the Initial Term or any Renewal Term of its election not to renew ("Non-renewal").

9.2 **Termination and Non-renewal, Rights and Obligations.** During the Initial Term of this Agreement, or any Renewal Term , either party may terminate this Agreement immediately upon the occurrence of any of the following events: (i) the other party has failed to cure a breach of this Agreement within thirty (30) days after receiving written notice thereof; (ii) the other party institutes proceedings under bankruptcy or insolvency laws, for corporate reorganization, receivership, dissolution or similar proceedings; (iii) proceedings under bankruptcy or insolvency laws, for corporate reorganization, receivership, dissolution or similar proceedings pending against the other party for more than ninety (90) days; (iv) the other party makes a general assignment for the benefit of creditors; (v) the other party becomes insolvent; or (vi) either party ceases to conduct business or to conduct the business relevant hereunder. Upon any termination or non-renewal of this Agreement, Customer's License to access and use the Software pursuant to Sections 2.4 and 2.5 are and shall be automatically and immediately revoked, and Customer shall (i) cease all further use of the Software and, de-install the Software and, at 3M's option, either return all copies of the Software (CSI) and Documents to 3M at Customer's expense or destroy all copies of the Software (CSI) and Documents. In the event the Software requires 3M to access Customer's Equipment for Customer to comply with this Section 9.2, Customer shall not unreasonably deny or delay 3M's access to such Equipment. Customer shall certify to 3M in writing that all copies have been returned or destroyed; (ii) pay all charges and fees outstanding (and no refund shall be due Customer for any charges or fees paid, except in the event that Customer has rightfully terminated the Agreement due to a breach by 3M, in which event Customer's sole remedy and 3M's sole obligation shall be a refund to Customer of a pro-rated portion of the current year's pre-paid Software license fees, if any); (iii) return to 3M any security devices which 3M loaned to Customer. Sections 2.1, 4, 5, 7 and 10 shall survive any termination of this Agreement.

10.0 GENERAL PROVISIONS

10.1 **Effect of Agreement.** This Agreement (including all Schedules, Exhibits and other attachments hereto) embodies the entire understanding between the parties with respect to the subject matter hereof and supersedes any and all prior understandings, oral or

written proposals and communications or other agreements, oral or written, relating thereto. Customer acknowledges that it has not been induced to enter into this Agreement by any representation or statement, oral or written, not contained in this Agreement.

10.2 **Amendments, Modifications.** Except as otherwise provided herein, any amendment hereof must be in writing and signed by both parties. In connection with this Agreement, 3M may from time to time accept receipt of one or more purchase orders from Customer, may acknowledge such receipt by returning one or more acknowledgment copies, and may issue invoices against any such purchase order. Any such act by 3M is for Customer's convenience only. The terms and conditions of this Agreement shall prevail over any conflicting or additional terms and conditions of any order or other document submitted by Customer at any time in connection with this Agreement. All such conflicting and additional terms and conditions are specifically rejected and do not form, and shall not form, any part of this Agreement.

10.3 **Interpretation, Priority.** The headings and captions contained in this Agreement are for convenience only and shall not constitute a part hereof. In the event of any conflict between a provision of this Agreement, any Schedule or Exhibit thereto, or a Document, such conflict shall be resolved in the following order of priority unless specifically stated otherwise (governing provision stated first): terms and conditions of this Agreement, Schedule, Exhibit, Document.

10.4 **Assignment.** This Agreement is binding on successors and assigns of the parties. Neither this Agreement nor any part or portion hereof shall be assigned, sublicensed, or otherwise transferred by Customer without 3M's prior written consent, and any attempt to do so shall be void.

10.5 **Force Majeure.** Neither party shall be responsible for failure to comply with this Agreement (other than an obligation to pay money) due to causes beyond its reasonable control including, without limitation, acts of God, war, or terrorism, natural disasters, fire, or riots.

10.6 **Announcements.** 3M, with Customer's prior written approval, may issue announcements concerning this Agreement to the trade press and recognized industry consultants.

10.7 **Notices.** Each party shall appoint a representative from its organization authorized to receive notices hereunder. All notices required to be given shall be given in writing by personal delivery, by certified or registered mail or by overnight carrier to the other party at the address listed on the face of this Agreement. Any change of address or representative shall be promptly communicated in writing to the other party.

10.8 **Severability, Enforcement.** Any provision of this Agreement, which is held to be void, invalid, unenforceable or illegal by a court, shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating the remaining portions hereof or affecting the validity or enforceability of such provision in any other jurisdiction.

10.9 **Governing Law.** This Agreement and any questions, claims, disputes or litigation concerning or arising from its creation, performance or termination, shall be governed by the laws of the state of ***Kentucky*** without giving effect to the conflicts of laws doctrines of any state.

10.10 **Dispute Resolution.** The parties shall attempt in good faith to resolve any controversy, claim or dispute (cumulatively "Dispute") arising from or relating to this Agreement by negotiations between representatives of the parties. In the event of litigation both parties hereby waive any right of trial by jury. Any cause of action arising from, or out of, the creation, performance or non-performance or termination of this Agreement, based upon breach of warranty, breach of contract, negligence, strict liability in tort or any other legal theory regardless of the form of such action must be commenced within one (1) year after (i) the date on which the breach occurs, or (ii) the date on which the non-breaching party obtains knowledge of the facts giving rise to such cause of action , whichever occurs later. The procedures herein are exclusive and shall be fully exhausted prior to the initiation of litigation; provided, however, that nothing herein shall preclude a party from taking any action necessary to preclude imminent and irreparable harm.

10.11 **No Third Party Beneficiaries.** The parties expressly acknowledge and agree that no third party is intended to be a beneficiary of any provision of this Agreement.

10.12 **Insurance.** During the term of this Agreement 3M shall maintain such policies of insurance coverage appropriate to the performance of its obligations under this Agreement.

10.13 **Exclusion from Participation**. 3M Health Information Systems hereby represents and warrants to Customer, to the best of its knowledge, that 3M Health Information Systems nor any of its officers, directors, or employees (collectively, the 3M Parties) is excluded from participation in any applicable Federal or State health benefits program (including, without limitation, Medicare or Medicaid). 3M shall promptly notify Customer in writing if any 3M Party is excluded from program participation. Notwithstanding any other provision of this Agreement, Customer shall have the right to terminate, without liability, this Agreement upon exclusion of any 3M Party from any such program.

10.14 **Compliance with Laws**. Each party shall comply, at its own cost and expense, with the provisions of all applicable federal, state, county and local laws, ordinances, regulations and orders pertaining to the performance of its obligations under this

Agreement. In the event that one party believes that the other may not be in compliance with one of the foregoing, it shall so notify the other party, which will promptly look into the matter and take any measures necessary to remedy any such non-compliance.

10.15 **Exhibits.** The following Exhibits shall be incorporated herein.

Exhibit A Authorized Sites

Exhibit B Software and Services Schedule

Exhibit C Business Associate Addendum

Exhibit D Third Party Software Terms and Conditions Part I & II

Exhibit E Customer's Quarterly Report

10.16 **Attachments.** The following Attachments shall be incorporated herein.

Attachment A Scope of Work (optional as required)

Exhibit A

AUTHORIZED SITES

Name Address	Contact Title Phone	Install Site (Y)
CorrectCare Integrated Health 366 South Broadway Lexington, KY 40508	Brian Cundiff	Y

Issue Date: *4/13/09* 3M Contract No: *95229-09*

Site ID: *2510479*
Batch: 95229

3M FORM SLA.CON.AUD.CON CODE.DOT v1.x

Exhibit B

SOFTWARE AND SERVICES SCHEDULE

ITEM	QTY	DESCRIPTION	LIST PRICE $	1st YEAR LICENSE FEES $	INSTALL & TRAINING FEES $
Part 1 Software					
		CPU TYPE: ***Networking (2 Users)***			
1.	1	3M™ Coding and Reimbursement System	7,917.00	3,959.00	N/A
2.	1	3M™ Reimbursement Calculation Software (Ohio Medicaid)	702.00	702.00	N/A
3.	1	3M™ Ohio Grouper	1,527.00	1,527.00	N/A

TOTAL FIRST YEAR ANNUAL SOFTWARE LICENSE FEES: $	**6,188.00**
TOTAL INSTALLATION & TRAINING FEES: $	**N/A**
TOTAL FIRST YEAR ANNUAL LICENSE, INSTALLATION & TRAINING FEES: $	**6,188.00**

License fees listed above are guaranteed for a period of ninety (90) days from the Issue Date listed below. If Customer does not execute this Agreement prior to the end of ninety (90) days, 3M may, at its option, adjust the License Fees to the then current list price less any applicable discount.

Issue Date: *4/13/09* Revision Date: *4/24/09* 3M Contract No: *95229-09*

95229

Site ID: *2510479*
Batch: 95229

3M FORM SLA.CON.AUD.CON CODE.DOT v1.x

Exhibit C

BUSINESS ASSOCIATE ADDENDUM

1. Parties:

Software License and Services Agreement #95229-09
("Covered Entity")

3M Company, together with its subsidiaries and affiliates (collectively referred to herein as "3M")
575 West Murray Boulevard
Murray, UT 84123-4611
("Business Associate")

2. Purpose:

Business Associate may provide certain services as set forth in the Software License and Services Agreement ("Agreement") to Covered Entity which may require the provision by Covered Entity of Protected Health Information ("PHI") and/or Electronic Protected Health Information ("EPHI") to Business Associate. As a result, Business Associate may be considered a Business Associate of Covered Entity as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Business Associate and Covered Entity intend to comply with the HIPAA Privacy Rule and Security Regulations (45 CFR Parts 160, 162 and 164) ("Privacy Rule" and "Security Regulations", individually; or "Privacy and Security Regulations", collectively). Therefore, to the extent required by HIPAA, and the regulations promulgated there under, Business Associate agrees to maintain the confidentiality of PHI and EPHI it receives from Covered Entity, if any. Whenever the term PHI is used in a provision in this Addendum, it shall mean, include and be applicable to EPHI. Whenever the term EPHI is used, it shall mean and be applicable to EPHI only.

3. Definitions:

Terms used in this Addendum have the same meaning as those terms in the Privacy and Security Regulations.

The terms PHI and EPHI when used in this Addendum shall have a meaning as defined by the Privacy and Security Regulations, but for the purposes of this Addendum shall be limited to PHI and/or EPHI received from, or created or received by Business Associate on behalf of, Covered Entity. Wherever the term PHI is used in a provision in this Addendum, it shall mean, include and be applicable to EPHI. Wherever the term EPHI is used, it shall mean and be applicable to EPHI only.

4. Obligations and Activities of Business Associate: Business Associate agrees, that with respect to PHI, it will:

a. not use or further disclose PHI other than as permitted or required by the Agreement or as Required By Law;

b. use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Addendum. Without limiting the generality of the foregoing, Business Associate will:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity;

(ii) Ensure that any agent, including a subcontractor, to whom it provides such EPHI agrees to implement reasonable and appropriate safeguards to protect it; and

(iii) Report to the Covered Entity any Security Incident of which it becomes aware;

c. report to Covered Entity any use or disclosure of the PHI not provided for in the Agreement of which it becomes aware;

d. ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same PHI restrictions and conditions that apply to Business Associate through this Addendum;

e. make available PHI maintained by Business Associate or its agents in accordance with this Addendum to Covered Entity upon reasonable notice and in accordance with applicable law;

f. incorporate any amendments or corrections to PHI maintained by Business Associate in a Designated Record Set in accordance with applicable law and to the extent applicable to this Addendum; Any such amendment or correction made to a Designated Record Set at the direction of the Covered Entity will be the responsibility of the Covered Entity.

g. make available the information required to provide an accounting of PHI disclosures made pursuant to applicable law and as required by this Addendum for the term of the Agreement;

h. make internal practices, books, and records, relating to the use and disclosure of PHI received from Covered Entity, available to the Secretary of the United States Department of Health and Human Services, in a reasonable time and manner or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with applicable law; and

i. mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.

5. **Permitted Uses and Disclosures by Business Associate:** Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI:

   a. on behalf of, or to provide services to, Covered Entity, as provided for in the Agreement and in accordance with the Privacy Rule;

   b. for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate;

   c. to provide Data Aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B); and

   d. to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

6. **Obligations of Covered Entity:** Covered Entity shall:

   a. notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI;

   b. notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI; and

   c. notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

7. **Term and Termination**

   a. Term. The Term of this Addendum begins on the Effective Date (above), and ends when the Agreement between Covered Entity and Business Associate has terminated or all PHI provided by Covered Entity to Business Associate is destroyed or returned to Covered Entity, whichever is later.

   b. Termination for Cause. If Business Associate breaches this Addendum, Covered Entity has the right, but not the obligation to either:

      (1) Provide an opportunity for the Business Associate to cure the breach or end the violation;

      (2) Immediately terminate the underlying Agreement(s) between Covered Entity and Business Associate; however, all rights and obligations arising prior to such termination shall remain in effect. All other Agreements between Covered Entity and 3M Company shall remain in effect in accordance with their terms; or

      (3) report the violation to the Secretary in accordance with applicable law only in cases where neither termination nor cures are feasible.

   c. Effect of Termination.

      (1) Except as provided in paragraph (2) of this section, upon termination of this Addendum, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI except as provided for in this Addendum.

(2) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall extend the security protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

8. Miscellaneous

a. Third Party Beneficiaries: Nothing expressed or implied in this Addendum is intended, nor shall be deemed, to confer any benefits on any third party.

b. Regulatory References. A reference in this Addendum to a section in the Privacy Rule or the Security Regulations means the section as in effect or as amended.

c. This Addendum supersedes and replaces any other agreement terms with 3M Health Information Systems with respect to the terms and obligations relating to HIPAA and PHI.

d. Amendment. The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Regulations and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

e. Survival. The respective rights and obligations of Business Associate under Section 7.c of this Addendum shall survive the termination of this Addendum.

f. Interpretation. Any ambiguity in this Addendum shall be resolved to permit Covered Entity to comply with the Privacy and Security Regulations.

Exhibit D

THIRD PARTY CONTENT TERMS AND CONDITIONS

Part I

AMA TERMS AND CONDITIONS

The following terms and conditions apply to Customer's use of 3M Software and Content containing *Current Procedural Terminology* and/or material published in *CPT® Assistant* (collectively referred to herein as "AMA Editorial Content") in addition to the terms and conditions set forth in the License Agreement ("Agreement"). In the event of a conflict between the terms and conditions in the Agreement and those set forth in this Exhibit D, with respect to Customer's use of the AMA Editorial Content, the terms and conditions of this Exhibit D shall control.

1. Grant of Rights Restrictions. Customer has a nontransferable, nonexclusive license to use the AMA Editorial Content contained within the 3M Software and Content solely for its internal purposes within the United States. Customer is prohibited from publishing, distributing via the Internet or other public computer based information system, creating derivative works (including translations), transferring, selling, leasing, licensing or otherwise making the AMA Editorial Content, or a copy or portion thereof, available to any unauthorized party. Customer's access to updated AMA Editorial Content depends upon a continuing contractual relationship between 3M and the AMA. Customer shall ensure that anyone with authorized access to the AMA Editorial Content will comply with the provisions of the Agreement, including this Exhibit. Any printing or downloading of *CPT® Assistant* from the 3M Software and/or Content must be solely for Customer's internal use, without any modification to the content, and in such a way that all references to the AMA are included.

2. Notices. CPT and *CPT Assistant* are copyrighted works of the American Medical Association. CPT is a registered trademark of the American Medical Association. The following U.S. Government Rights notice shall apply: *U.S. Government Rights. This product includes CPT and/or CPT Assistant which is commercial technical data and/or computer data bases and/or commercial computer software and/or commercial computer software documentation, as applicable which were developed exclusively at private expense by the American Medical Association, 515 North State Street, Chicago, Illinois, 60610. U.S. Government rights to use, modify, reproduce, release, perform, display, or disclose these technical data and/or computer data bases and/or computer software and/or computer software documentation are subject to the limited rights restrictions of DFARS 252.227-7015(b)(2) (November 1995) and/or subject to the restrictions of DFARS 227.7202-1(a) (June 1995) and DFARS 227.7202-3(a) (June 1995), as applicable for U.S. Department of Defense procurements and the limited rights restrictions of FAR 52.227-14 (June 1987) and/or subject to the restricted rights provisions of FAR 52.227-14 (June 1987) and FAR 52.227-19 (June 1987), as applicable, and any applicable agency FAR Supplements, for non-Department of Defense Federal procurements.*

3. Backup Rights. Customer may make backup copies of the 3M Software and/or Content containing AMA Editorial Content for backup or archival purposes only provided that all notices of proprietary rights, including trademark and copyright notices, appear on all backup or archival copies made.

4. Warranty Disclaimer. TO THE FULLEST EXTENT POSSIBLE UNDER APPLICABLE LAW, ALL WARRANTIES (EXPRESS AND IMPLIED) INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF MERCHANTABILITY, TITLE, NON-INFRINGEMENT OR FITNESS FOR A PARTICULAR PURPOSE AND THOSE ARISING FROM TRADE USAGE OR COURSE OF DEALING ARE DISCLAIMED WITH RESPECT TO THE AMA EDITORIAL CONTENT. CUSTOMER'S USE OF THE AMA EDITORIAL CONTENT AS CONTAINED IN THE 3M SOFTWARE AND/OR CONTENT IS "AS IS" WITHOUT ANY LIABILITY TO 3M OR THE AMA INCLUDING, WITHOUT LIMITATION, ANY LIABILITY FOR DIRECT, INDIRECT, INCIDENTAL, SPECIAL OR CONSEQUENTIAL DAMAGES, OR LOST PROFITS FOR SEQUENCE, ACCURACY, OR COMPLETENESS OF DATA, OR THAT THE AMA EDITORIAL CONTENT WILL MEET CUSTOMER'S REQUIREMENTS. THE SOLE RESPONSIBILITY OF THE AMA IS TO MAKE AVAILABLE TO 3M REPLACEMENT COPIES OF THE AMA EDITORIAL CONTENT IF THE DATA IS NOT INTACT. THE AMA DISCLAIMS ANY LIABILITY FOR ANY CONSEQUENCES DUE TO USE, MISUSE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THE AMA EDITORIAL CONTENT.

Exhibit D

THIRD PARTY CONTENT TERMS AND CONDITIONS

PART II

HEALTH FORUM TERMS AND CONDITIONS

3M's Coding Reference Software contains AHA Coding Clinic™ for ICD-9-CM; and 3M's Coding Reference Plus Software contains ICD-9-CM Coding Handbook, Revised Edition, by Faye Brown, and AHA Coding Clinic™ for HCPCS. To the extent Customer has licensed the 3M Coding Reference Software or the 3M Coding Reference Plus Software, the following terms and conditions apply to Customer's use of such Software in addition to the terms and conditions set forth in the License Agreement ("Agreement"). In the event of a conflict between the terms and conditions in the Agreement and those set forth in this Exhibit D, with respect to Customer's use of such Software, the terms and conditions of this Exhibit D shall control.

ICD-9-CM Coding Handbook, Revised Edition, by Faye Brown, is copyrighted by Health Forum, LLC, Chicago, Illinois, which licenses its use. No portion of ICD-9-CM Coding Handbook may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior express, written consent of Health Forum, LLC.

It is understood that Health Forum, LLC did not enter the ICD-9-CM Coding Handbook information and data into the computer and therefore Health Forum, LLC is not responsible for the accuracy, completeness or appropriateness of the information. Health Forum, LLC, and 3M make no warranties of merchantability or fitness for a particular purpose. Health Forum, LLC, shall have no liability to anyone, including 3M and Customer, for lost profits or indirect or consequential damages. Health Forum, LLC, makes no warranties of any kind with respect to 3M, its products or services.

AHA Coding Clinic™ for ICD-9-CM is copyrighted by the American Hospital Association ("AHA"), Chicago, Illinois, which licenses its use. No portion of AHA Coding Clinic™ for ICD-9-CM may be copied without the express, written consent of Health Forum, LLC.

It is understood that AHA did not enter the AHA Coding Clinic™ for ICD-9-CM information and data into the computer and therefore AHA is not responsible for the accuracy, completeness or appropriateness of the information. AHA and 3M make no warranties of merchantability or fitness for a particular purpose. AHA shall have no liability to anyone, including 3M and the Customer, for lost profits or indirect or consequential damages. AHA makes no warranties of any kind with respect to 3M, its products or services.

AHA Coding Clinic™ for HCPCS is copyrighted by the American Hospital Association ("AHA"), Chicago, Illinois, which licenses its use. No portion of AHA Coding Clinic™ for HCPCS may be copied without the express, written consent of Health Forum, LLC.

It is understood that AHA did not enter the AHA Coding Clinic™ for HCPCS information and data into the computer and therefore AHA is not responsible for the accuracy, completeness or appropriateness of the information. AHA and 3M make no warranties of merchantability or fitness for a particular purpose. AHA shall have no liability to anyone, including 3M and the Customer, for lost profits or indirect or consequential damages. AHA makes no warranties of any kind with respect to 3M, its products or services.

The printing or downloading of ICD-9-CM Coding Handbook, AHA Coding Clinic™ for ICD-9-CM and AHA Coding Clinic™ for HCPCS (collectively, the "HF Documentation") or any portion thereof, is prohibited, other than the printing of an excerpt from HF Documentation on a specific topic without any modification to the excerpt for internal use only by the Authorized Site as long as the source of the excerpt(s) is printed on the printout(s).

The text of HF Documentation is and will remain inaccessible to other programs capable of generating paper printouts of HF Documentation (excluding the print screen functionality of Windows software) by encrypting all files containing source text of HF Documentation.

EXHIBIT E

CUSTOMER'S QUARTERLY REPORT

See attached reporting template

Attachment A

SCOPE OF WORK

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NEVADA STATE BUSINESS LICENSE

SECRETARY OF STATE

STATE OF NEVADA

NEVADA STATE BUSINESS LICENSE

CORRECTCARE-INTEGRATED HEALTH, INC.
Nevada Business Identification # NV20131631138

Expiration Date: October 31, 2014

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

This license shall be considered valid until the expiration date listed above unless suspended or revoked in accordance with Title 7 of Nevada Revised Statutes.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on October 29, 2013

ROSS MILLER
Secretary of State

This document is not transferable and is not issued in lieu of any locally-required business license, permit or registration.

Please Post in a Conspicuous Location

You may verify this Nevada State Business License online at www.nvsos.gov under the Nevada Business Search.

NV TPA LICENSE VERIFICATION

Department of Business and Industry
Nevada Division of Insurance

- Help me find...
  - Self-Insured Workers' Compensation
  - File a Complaint
  - About Us
  - Contact Us
  - Sitemap
  - State of Nevada Links

- Consumers
- Health Insurance Rates
- Health Care Reform
- Licensing
- Insurers
- Captive Insurers
- News & Notices

New Search

CorrectCare-Integrated Health, Inc

Address:

366 S Broadway
Lexington, KY 40508

Phone

859-225-7999

URL:

Email:

Status:

Active

Date:

12/4/2013

License Type	License Number	Original Issue Date	Status	Effective Date	Expiration Date
Non-Res. Third Party Admin.	923520	12/4/2013	Active	12/4/2013	1/1/2017

Qualification Type	Original Issue Date	Status	Effective Date
TPA2-SF Health Benefit Program	12/4/2013	Active	12/4/2013

- Consumers
- Health Insurance Rates
- Healthcare Reform
- Licensing
- News & Notices
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ATTACHMENT B, TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE

WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with ***all*** the terms and conditions specified in this Request for Proposal.

YES **X** I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

If the exception and/or assumption require a change in the terms in any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed in the tables below. If vendors do not specify in detail any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

CorrectCare Integrated Health, Inc.
Company Name

Signature

Linda Goins, President
Print Name

Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)
1	9.2.3.5 B	34 of 59	In order to obtain our Nevada TPA license, the Nevada Department of Insurance has required us to submit the attached addendum to the contract which incorporates certain Nevada Revised Statutes.

ASSUMPTION SUMMARY FORM

ASSUMPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

ASSUMPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

This document must be submitted in Tab V of vendor's technical proposal

CLAIMS ADMINISTRATION ADDENDUM

THIS CLAIMS ADMINISTRATION ADDENDUM is entered into this the ___ day of _____, 2014, to be effective as of the _____day of _____, 2014 by and between CorrectCare-Integrated Health, Inc., 366 South Broadway, Lexington, Kentucky 40508, a Kentucky Corporation ("CCIH") and the State of Nevada acting by and through the Nevada Department of Corrections ("NDOC").

WHEREAS, the NDOC has a constitutional requirement to provide medical care to inmates incarcerated in its penal institutions; and

WHEREAS, the NDOC has directly contracted with preferred provider networks for the benefit of the NDOC (Preferred Provider Arrangement) in order to meet that constitutional requirement; and

WHEREAS, CCIH is an entity that is capable of adjudicating and paying claims for health care services provided to inmate populations; and

WHEREAS, CCIH is not an insurer, re-insurer, insurance policy issuer or insurance underwriter, nor does any insurance company have an ownership interest in CCIH; and

WHEREAS, CCIH has been awarded a Contract for Third Party Administrative Services in response to the State of Nevada Purchasing Division Request for Proposal: 3086 (release date: October 24, 2013) to adjudicate and pay claims for health care services provided to NDOC inmate populations; and

WHEREAS, the parties desire to amend the Contract for Services of Independent Contractor ("Agreement") dated _____, 2014 to further clarify and codify CCIH's obligations and responsibilities as a licensed Third Party Administrator in the State of Nevada (NRS 683A.0805 through NRS 683A.0893, inclusive).

NOW, THEREFORE, in consideration of the mutual promises and covenants contained in this Addendum and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

WITNESSETH

A. Duties and Responsibilities of CCIH

1. CCIH shall furnish, staff and maintain an office with facilities and personnel adequate to perform the duties of claims processing, including payment of claims, and to answer the inquiries of the NDOC and medical providers with respect to the same. CCIH's office shall be open daily, Monday through Friday, during normal working hours except legal holidays. CCIH shall furnish all necessary telephone service, and assume all routine daily mailing costs with respect to handling, processing, and payment of claims for the Preferred Provider Arrangement.

2. CCIH may, but has no present intention to advertise its business with the NDOC. In the event advertising should be necessary for CCIH to meet the obligations of the Agreement with the NDOC, CCIH will do so only after prior written approval has been received from the NDOC.

3. CCIH will maintain at its principal office adequate books and records of all transactions between CCIH, the NDOC, the inmates in the custody of the NDOC, and the preferred provider networks for the duration of this Addendum and five (5) years after the transaction to which they respectively relate. Such books and records will be maintained in accordance with prudent standards of insurance recordkeeping and the regulations of the Commissioner of the Nevada Department of Insurance ("NDOI").

a. CCIH understands and agrees that all health files and all forms required for filing a claim which are maintained by it pursuant to this Addendum or otherwise for the NDOC shall be and remain the property of the NDOC and shall be delivered to the NDOC upon demand.

b. The Commissioner of the NDOI may examine, audit and inspect the books and records maintained by CCIH under the provisions of this section to carry out the provisions of NRS 679B.230 to 679B.300, inclusive. CCIH will provide any state or federal agency and/or office of insurance regulation access to all such books and records.

c. The names and addresses of the NDOC inmates ("insured" persons of which addresses would be the NDOC prison facility in which the inmate was housed at the time of each claim) and any other material which is in the books and records of CCIH are confidential except as otherwise provided in NRS 239.0115 and except when used in proceedings against CCIH.

d. The NDOC may inspect and examine all books and records to the extent necessary to fulfill all contractual and/or constitutional obligations to inmates, subject to restrictions if any in the written Agreement between the NDOC and CCIH.

4. CCIH and the NDOC shall establish a checking account into which the NDOC will deposit funds and from which CCIH will disburse checks for inmate claims ("CCIH / NDOC claims account"). CCIH shall supply documentation to the NDOC of the claims processed. The NDOC, after review of the claims processed by CCIH, shall authorize and transfer funds to the CCIH / NDOC claims account for disbursement by CCIH. Upon verification of the NDOC's deposit to the CCIH / NDOC claims account, CCIH shall disburse benefit checks and explanation of benefits to the physician or medical service facility (sometimes referred to herein as "claimants"), whichever is appropriate. Claims payments forwarded by the NDOC to CCIH shall not be deemed to have been paid to the claimant until such payments are received by the claimant. Nothing in this section limits any right of the NDOC against CCIH resulting from the failure of CCIH to make payments to the claimants.

a. All insurance charges and premiums collected if any by CCIH on behalf of the NDOC (insurer) and return premiums if any received from the NDOC will by held by CCIH in a fiduciary capacity.

b. Money will be remitted by CCIH within fifteen (15) days to the person or persons entitled to it, or be deposited within fifteen (15) days in one or more fiduciary accounts established and maintained by CCIH in a bank, credit union or other financial institution in the State of Nevada. The fiduciary account(s) will be separate from the personal or business account(s) of CCIH.

c. CCIH will maintain the CCIH / NDOC claims account as a separate claims paying account for the NDOC. Charges or premiums collected for or on behalf

of another CCIH client will not be deposited into the CCIH / NDOC claims account, and in the event that should occur, CCIH will cause the bank, credit union or other financial institution where the fiduciary account is maintained to record clearly the deposits and withdrawals from the account on behalf of each client. CCIH will take prompt measures to ensure against any such future reoccurrence.

d. CCIH will promptly obtain and keep copies of the records of the CCIH / NDOC claims account clearly recording the deposits in and withdrawals from such account on behalf of the NDOC, and upon request from the NDOC, will furnish the NDOC with copies of the records which pertain to the NDOC.

e. CCIH will not pay any claim by withdrawing money from the CCIH / NDOC claims account in which any premiums or charges may be deposited.

f. Withdrawals from the CCIH / NDOC claims account will be made as provided in the Agreement between the NDOC and CCIH for any:

i. Remittance to the NDOC.

ii. Deposit in an account maintained in the name of the NDOC.

iii. Transfer to and deposit in an account for the payment of claims.

iv. Payment to a group policyholder, if any, for remittance to the NDOC if entitled to the money (no such payments should arise under the Agreement because there is no group policyholder).

v. Payment to CCIH of the commission, fees or charges of CCIH (CCIH will only be paid a per inmate fee as set forth hereinbelow).

vi. Remittance of return premiums, if any, to persons entitled to them.

5. Providers shall complete and submit industry standard claim forms to CCIH. CCIH shall check the claim forms and information submitted, and if necessary, use its best effort to obtain any missing information directly from the NDOC, the medical service facility or physician. Upon receipt of complete information with respect to a claim, CCIH shall review eligibility and any other relevant authorizations, and process and re-price such claims in accordance with the NDOC's then existing Preferred Provider Arrangements, contracts between Provider(s) and the NDOC, governmental requirements, or any combination thereof.

a. Except as otherwise provided in subsection b. below, CCIH will approve or deny a claim within thirty (30) days after CCIH receives the claim. If the claim is approved, CCIH will pay the claim within thirty (30) days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, CCIH will pay interest on the claim at a rate of interest equal to the prime rate of the largest bank in Nevada, as ascertained by the Nevada Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus six percent (6%). The interest will be calculated from thirty (30) days after the date on which the claim is approved until the date on which the claim is paid.

b. If CCIH requires additional information to determine whether to approve or deny a claim, CCIH will notify the claimant of its request for the additional information within twenty (20) days after receiving the claim. CCIH will notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. CCIH will approve or deny the claim within thirty (30) days after receiving the additional information. If the claim is approved, CCIH will pay the claim within thirty (30) days after receiving the additional information. If the approved claim is not paid within that period, CCIH shall pay interest on the claim in the manner prescribed in subsection a. above.

c. CCIH will not request a claimant to resubmit information that the claimant has already provided to CCIH, unless CCIH provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

d. CCIH shall not pay only part of a claim that has been approved and is fully payable.

e. CCIH understands and agrees that a court may award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this paragraph.

f. CCIH understands and agrees that the payment of interest provided for in this paragraph for the late payment of an approved claim may be waived only if the payment was delayed because of an act of God or another cause beyond the control of CCIH.

g. CCIH understands and agrees that the Commissioner of the NDOI may require CCIH to provide evidence which demonstrates that CCIH has substantially complied with the requirements set forth in this paragraph, including, without limitation, payment within thirty (30) days of at least ninety five percent (95%) of approved claims or at least ninety percent (90%) of the total dollar amount for approved claims.

h. CCIH understands and agrees that if the Commissioner of the NDOI determines that CCIH is not in substantial compliance with the requirements set forth in this paragraph, the Commissioner may require CCIH to pay an administrative fine in an amount determined by the Commissioner. Upon a second or subsequent determination that CCIH is not in substantial compliance with the requirements set forth in this paragraph, CCIH understands and agrees that the Commissioner may suspend or revoke the certificate of registration of CCIH.

6. Each claim paid by CCIH from money collected for or on behalf of the NDOC will be paid by check or draft upon and as authorized by the NDOC.

7. CCIH will provide with any payment(s) to a health care provider an explanation of services being reimbursed which includes, at a minimum, the patient's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is being made.

8. CCIH shall cooperate fully with the NDOC as to any investigation, review or inquiry regarding a claim determination.

9. CCIH shall maintain a record of any and all inquiries made with respect to a claim determination and the disposition of the same. These records or summaries thereof shall be made available to the NDOC at such intervals as shall be established from time to time.

10. CCIH agrees to execute, acknowledge, and deliver any and all instruments that may be deemed by the NDOC necessary in or to the premises, relative to this Addendum and/or its duties hereunder.

B. Compensation to CCIH

1. For performing the functions of claims processing for this Agreement and assuming the responsibilities of such functions, CCIH shall invoice the NDOC during the term of this Agreement at the end of each month in which services are rendered in an amount equal to _____ per inmate.

a. Compensation to CCIH shall in no way be contingent on claims experience, or on the savings realized by CCIH in adjusting, settling or paying the losses covered by the NDOC.

b. CCIH will deposit such invoiced amounts in its own account, separate from the CCIH / NDOC claims account or any other private claims account that it may maintain for either the NDOC or any other client.

C**. Term**

1. The term of this Addendum shall run concurrently with the initial and any renewal term of the Agreement and shall terminate in accordance therewith.

D. Miscellaneous

1. This instrument constitutes and contains the whole and exclusive agreement between the parties with respect to the subject premises, and no modification hereof or addition hereto shall be valid or enforceable unless evidenced in writing and signed by them both.

2. Any notices to be given hereunder shall be deemed sufficiently given when sent by certified United States mail, postage prepaid.

(a) To the NDOC as follows:

_____
_____
_____

(b) To CCIH as follows:

CorrectCare-Integrated Health, Inc.
366 South Broadway
Lexington, Kentucky 40508

Such addresses may be changed by either party by written notices as to the new address.

3. The headings contained in this Addendum are for convenience only and shall not be interpreted to limit or otherwise affect the provisions of this Addendum.

4. The parties shall comply with the terms of the Contract for Third Party Administrative Services let in response to the State of Nevada Purchasing Division Request for Proposal: 3086 (release date: October 24, 2013), or this Addendum, whichever is more stringent.

IN WITNESS WHEREOF, the parties hereto have caused this Addendum to be signed by their officers duly authorized on the day and year first above written, and for themselves, their successors and assigns, do hereby agree to the full performance of the covenants and agreements herein before set forth.

CORRECTCARE-INTEGRATED HEALTH, INC.	**NEVADA DEPARTMENT OF CORRECTIONS**
By: _____	**By: _____**
Linda Goins, President	**Name, Title**

Section 3 – Scope of Work

3. SCOPE OF WORK

The successful vendor will process non-Medicaid medical and dental claims for inmates who have had health care services and/or treatments outside the prison or from outside providers. The claims will be paid from an account funded by NDOC. The vendor will coordinate with NDOC and NDOC's Preferred Provider Organization (PPO) Network(s). The current PPO networks used by NDOC are Multiplan for southern Nevada and Hometown Health for northern Nevada. NDOC currently provides its own Utilization Review. Coordination with NDOC will include receiving participant eligibility dates and service authorization information to determine eligibility.

The successful vendor may be required to appear before necessary legislative governmental meetings, and possibly, the Interim Finance Committee of the Nevada State Legislature.

CorrectCare – Integrated Health (CorrectCare) proposes to process non-Medicaid medical and dental claims for NDOC inmates as described above, including receipt of eligibility and authorization information and coordination with PPO networks and NDOC Utilization Review.

3.1 GENERAL VENDOR REQUIREMENTS9

Prospective vendors must agree to comply with listed minimum requirements.

3.1.1 Vendor shall provide all usual services incident to the settlement of claims in accordance with plan provisions, including but not limited to:

Providing appropriate forms;
Limited medical review;
Adjudication;
Records retention;
Check issuance;
Overpayment recovery;
Resolution of provider inquiries; and
Payment discrepancies.

CorrectCare will provide the above identified minimum requirements.

3.1.2 NDOC prefers that the selected TPA vendor have an office in Nevada, but it is not required by law. If selected, where would the claims be paid by the vendor?

CorrectCare will process NDOC claims from its office in Sacramento, California. CorrectCare will issue checks from this same office from a bank located inNevada per its TPA licensure requirements.

3.1.3 Vendors shall provide a copy of all appropriate State/County/City licensure with their response.

All appropriate licensure is included with this submission.

3.1.4 Vendor shall have a Third Party Administrator's license issued by the Nevada Division of Insurance prior to approval by the Nevada State Board of Examiners.

CorrectCare is a licensed Third Party Administrator in the State of Nevada.

3.1.5 Vendor shall have a Nevada Third Party Administrator's bond in an amount required by the Division of Insurance.

CorrectCare has a Nevada TPA bond in the amount designated by the DOI. That amount will be increased if necessary.

3.1.6 Vendor shall have the capability of interfacing with the PPO to electronically re-price claims.

CorrectCare has established and maintained electronic interfaces with both regional and national PPO Networks for its correctional clients. Currently, CorrectCare interfaces with Health Net for California Correctional Health Care Services (CCHCS) and Healthlink for the Kentucky Department of Corrections. CorrectCare also interfaces with Prime Health Network for correctional clients in Texas, New Jersey, Florida, North Carolina, and Tennessee. CorrectCare accesses Multiplan and Stratose as a wrap networks for non-participating providers.

3.1.7 Vendor shall provide Internet or other acceptable access for use by authorized NDOC staff when accessing vendor's claims processing system and printing information concerning NDOC inmate acclaims an status information.

CorrectCare utilizes WLT software for its claims processing system. The NDOC and Nevada healthcare providers will have access to claim status and history via the CorrectCare reports portal or the WLT provider portal. Through the WLT portal, providers will only be able to view and print information related to their Tax Identification number while NDOC designated individuals will have access to all providers' information. NDOC personnel will have the ability to access additional reports and queries from the CorrectCare reports portal.

3.1.8 Vendor's customer service representatives shall be available by calling a toll-free, national telephone number between the hours of 8:00 a.m. and 5:00 p.m. Pacific Time, Monday through Friday, except State-recognized holidays.

CorrectCare's California business hours are 6:00 a.m. to 6:00 p.m. Pacific Time, Monday through Friday with the exception of the following holidays: New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Day. CorrectCare personnel will be available for customer service and claim questions during those hours. Our team will always have someone available to contact in urgent situations. A toll-free, national telephone number will be provided

3.2 ELIGIBILITY SYSTEM REQUIREMENTS

3.2.1 Vendor's eligibility system must store, at a minimum, the following information for each inmate:

Name;
Birth date;
Location;
NDOC ID Number;
Effective date;
Termination date;
Boarder status effective date; and
Boarder status termination.

CorrectCare's claim eligibility system will store the above information. Boarder status may need to be handled under a separate plan or treated as a location to differentiate those dates from the NDOC effective and termination dates.

3.2.2 Awarded vendor's eligibility system must be available with online access.

Eligibility information can be accessed online through the WLT Claim System provider portal. NDOC staff will also have access through this portal.

Eligibility for each prison inmate is determined by the value in an "eligibility field," which is contained on the inmate identifier record.

The inmate identifier record is stored electronically and updated daily and/or weekly by the NDOC Division of Offender Management.

3.2.3 Awarded vendor's systems environment must accept daily and/or weekly electronic transmission of an updated inmate identifier file, which contains changes and updates to NDOC inmate eligibility status. Vendor's eligibility system must be integrated with the claims system so that eligibility is automatically checked on every claim.

CorrectCare will work with NDOC to define the specifications for this interface. Currently, CorrectCare accepts a daily eligibility file for the Louisiana Department of Public Safety and Corrections and the Kentucky Department of Corrections. Eligibility for California inmates is handled through a daily submission of information from the claims to a web service application for verification.

3.2.4 Awarded vendor's system must be capable of identifying eligibility exceptions, i.e., claim payment denials due to participant ineligibility.

CorrectCare's claims processing system automatically denies claims payment on any participant whose eligibility record shows inactive or terminated.

3.2.5 Awarded vendor's eligibility system must store historical information. The system shall indicate all past eligibility effective dates and termination dates, not just positive records.

CorrectCare's claims system tracks and maintains all effective dates and termination dates in an inmate's profile line by line.

3.2.6 Boarder Status effective date and termination date is an identifier field which indicates an inmate is being housed in an NDOC facility under an Interstate Compact or other inter-jurisdictional agreement.

CCIH proposes to work with NDOC on how to best handle Boarder's as opposed to NDOC inmates. There are several options that can identify a boarder – one of those being a separate location code set; another being a separate plan number.

3.2.7 Awarded vendor shall receive and maintain a claims history database.

CorrectCare extracts information from claims data both within the claims system and from a data base external to the system. For example, while inmate and provider demographic information, claim coding, and payment amount would be inside the claims system, discharge status and/or fiscal codes specific to DPS&C would be stored in the external data base. Data from the Claim system is extracted and combined with the external data. The combined data is then available through the CorrectCare Reports Portal.

The database will be accessible by NDOC personnel online via secure website to view individual inmate claims history or specific claim information.

NDOC personnel will have the ability to choose from multiple reports, such as Paid Claims, Claims in Process, Claims by Provider, Claims by Institution, and other reports as identified in section 3.2.8 below or as desired.

The awarded vendor shall provide the State with a copy of the documentation that explains the definitions, interactions, relationships, calculations, and derivations of fields and records for vendor's claim system.

CCIH will provide instructions and support for use of the claims portal and all reports will have a definition document. The definition document is accessible electronically from the screen when the report is selected.

3.2.8 The awarded vendor shall provide real-time report generation capability for the claims history database. Reports should be available in PDF format or downloadable to an Excel spreadsheet. Standard reports should include:

CorrectCare provides many of the reports listed below to existing clients through its reporting data base and portal. The data base is updated 4 times per day to assure all data is current. During the implementation phase, we propose to work

with NDOC to further define the desired fields in each of these reports. All reports will be available in PDF format and can also be downloaded to an Excel spreadsheet.

Administrative Reports

A. Check register reconciliation;
B. Outside medical and dental expenses;
C. Check Detail Reports;
D. Check register reports by patient name;
E. Check register reports by provider ID;
F. Check adjustment reports; and
G. Boarder Status.

Refund reports

Overpayment reports

Claim Detail Reports

H. Claim reports by location;
I. Claim reports by diagnosis;
J. Claim reports by patient ID;
K. Claim reports by provider ID; and
L. Claim reports by DOS.

Claim Summary Reports

M. Claim turn around;
N. Cost of benefit by location;
O. Denied claims;
P. Hospitalization summary;
Q. Paid claims by month;
R. Paid claims by paid date; and
S. Paid claims by provider.

Dental Claims

T. Denied dental claims;
U. Closed out dental claims;
V. Paid dental claims by month;
W. Paid dental claims by paid date; and
X. Paid dental claims by provider.

Recap Summary Reports

Y. Age and sex recaps;
Z. Dental procedure recaps;
AA. Diagnosis code recaps;
BB. Explanation code recaps;
CC. Plan recaps;

DD. Procedure code recaps;
EE. Provider recaps; and
FF. Service code recaps.

Vendor must allow reports to be generated with user-definable search criteria such as (but not limited to) dates of service, dates of payment, and institution (inmate location). Vendor will provide at no extra cost custom reports that are not available within the standard query.

Many of the queries through CorrectCare's Reports Portal allow the user to define the search by dates of service, dates of payment, location, and/or provider. Additional user-defined criteria can be incorporated as desired. CorrectCare will also provide other requested and ad hoc reports from claims data at no additional cost. Timeframes and desired fields within the above reports can be explored and agreed upon during the roll out phase.

Vendor's claims payment system must automatically edit for the following:

GG. Hospital pre-admission authorization;
HH. Authorized Length of Stay (LOS); and
II. Authorized procedures.

CorrectCare's claims processing system has all of the above-listed capabilities.

3.3 UTILIZATION REVIEW REQUIREMENTS

Provider must include the following services:

3.3.1 The system must provide NDOC staff the ability to issue payment authorization or denial by incident and/or dollar amount.

The NDOC's group and plan will be set up so that authorization and/or payment amount parameters are in place. Any claims that fall outside of these parameters will be flagged to indicate that this information must be provided prior to finalizing the claim.

3.3.2 The system must be flexible enough to hold NDOC information necessary for statistical information, such as, but not limited to:

CorrectCare will work with NDOC on determining the best method of storing statistical information related to utilization review. Some initial suggestions are indicated below

Number of inmates referred to outside consultants by each staff physician;

Information on referring staff physician can most likely be stored and reported upon if included in the authorization file

Number of inmates attending each on-site clinic each month; and

By instructing providers to use Place of Service Code 9, Prison/Correctional facility, this information can be stored and reported upon.

List of inmates by authorization code.

Reports will be available for multiple inmates served by one authorization code, such as for an onsite clinic day.

3.3.3 The system must allow access to provider's database for UR determinations.

CorrectCare will have a provider file available so that UR personnel can select preferred network providers when making UR determinations. This file will be made available in a format compatible with NDOC's utilization software.

3.3.4 The system must allow access to PPO information.

CorrectCare will make PPO information available to NDOC personnel as needed.

3.3.5 The system must provide NDOC staff the ability run daily, weekly, and monthly reports which include, but are not limited to:

Average length of stay;
Dates of service; and
A follow-up listing for concurrent review.

CorrectCare's system will allow the ability to run daily, weekly, and monthly reports including average length of stay and by dates of service. Concurrent review follow up listing is disregarded per the question/answer document/amendment.

3.4 HIPAA REQUIREMENTS

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996. HIPAA's Administrative Simplification provisions address several issues concerning health care transactions including:

3.4.1 Electronic Data Interchange (EDI) Standards for electronic health care transactions;

CorrectCare's system is compliant with HIPAA's EDI Standards for electronic health care transactions.

3.4.2 Standards for medical data code sets; and

CorrectCare's system uses HIPAA-compliant standards for medical data code sets

3.4.3 Unique identifiers for providers and individuals.

3.4.4 HIPAA's other provisions include**:**

Security standards for all - 1) health information that is maintained or transmitted electronically, and 2) electronic signatures; and Regulations protecting the privacy of individually identifiable health information.

CorrectCare's systems and processes adhere to HIPAA requirements.

3.4.5 Proposing vendors must specify vendor's state of compliance with all HIPAA requirements.

Both CorrectCare's system and policies are compliant with all HIPAA requirements, including those for security standards and protecting the privacy of health information.

3.4.6 Vendor must be able to process transactions using ICD-10-CM Diagnosis Codes, CPT Procedure Codes, HCPCS Procedure Codes, NDC Drug Codes and ADA Code on Dental Procedures and Nomenclature for dental services which have been identified in the HIPAA regulations.

All claims are processed using CPT, HCPCS, ASA, DRG, ADA, and/or standard revenue codes, user defined codes, and modifiers. All CCIH systems are 5010 compliant, and all processing, procedure, diagnostic, and revenue codes are captured and available for tracking and reporting purposes. CorrectCare's claim system is ICD-10 compliant, and testing is currently proceeding with PPO network interfaces.

3.4.7 Vendor must specify what data content, conditions, codes, and formats their system currently supports and/or uses, if different from those specified in 3.4.6.

CorrectCare's system supports all data, conditions, codes, and formats noted throughout this section.

3.5 SECURITY STANDARDS

3.5.1 Does the system have ID and password protection to guard against incorrect internal use or access to the data?

Yes, CorrectCare's system employs the Kerberos authentication protocol, as part of Microsoft's Active Directory to authenticate computer and user access to computing resources and data.

3.5.2 Have plans been made for the system to produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?

Yes, domain authentication auditing is enabled throughout our Active Directory environment. This level of auditing tracks success or failure of logons to our computing environment. Object access auditing is enabled on HIPAA sensitive directories and files. This level of auditing logs all access with timestamps to files and data within these directories.

3.5.3 Please explain how security is set up in the system, as well as the different levels of security.

Physical security to computing resources, i.e. servers and computing infrastructure, is accomplished by restricting access to these devices by security alarms, locked doors, and vault combinations. Keys and alarm codes are only available to infrastructure personnel.

Digital security is accomplished by Kerberos authentication to the computing resources, themselves, and secure socket layer (SSL) over the network. Site-to-Site data transmission is encrypted by 3DES/HMAC MD5 (IKE) security protocols.

Within the Claims Processing System, security levels are based on job responsibilities. No processor can enter agents or providers. No eligibility personnel have access to paying claims. No check printing personnel have access to claims processing or eligibility functions. Security levels are set from "no access" to "inquire only" or the "ability to run a program." No one has the full administrator's access except selected executive personnel.

3.6 CLAIMS PROCESSING SERVICES

This section contains additional specifications the awarded vendor should provide to fulfill the requirements of the contract. Please indicate your company's ability to meet the specifications. If your ability to meet a specification differs from the description offered, please indicate your method or provision and note such on ***Attachment B*** of this RFP. Some items request specific information about your claims processing system. Please provide any information requested.

3.6.1 Preferred Provider Organization System Interaction

List all PPO networks for which you currently process claims.

CorrectCare currently processes PPO network claims for HealthNet; First Health, Healthlink, and Prime Health Services. CorrectCare also prices claims at a variety of Medicare and Medicaid-based legislated rates. CorrectCare uses Multiplan and Stratose for wrap networks.

Describe any differences between how your system is updated/ claims are processed for your own PPO network and how claims are processed outside your network.

CorrectCare uses different PPO Networks for different clients. PPO Networks are attached at the group level, so claims within the PPO network are priced automatically based on the fee schedule or submitted to the PPO network for pricing through 5010-compliant EDI transactions. For non-participating providers, claims are priced at penal code or legislated rates when applicable or submitted electronically to a wrap network for pricing.

Describe how the system will flag PPO providers and apply negotiated PPO rates during claims processing.

PPO Networks are attached at the group and provider level; therefore, any claims for that group will have the negotiated PPO rates applied, either directly through the fee schedules attached to the provider record or by interface with the PPO network for pricing application.

Describe the extent to which claims examiners will apply manual processing steps to adjudicate claims from these providers.

Manual steps are used only when non-participating provider claims are priced. Examiners will either use an automated Medicare pricing tool created, maintained, and updated from the CMS website or will add pricing information received from the wrap networks

3.6.2 Vendor shall settle all claims received after the proposed effective date of July 1, 2014. Although it is anticipated the current administrator will pay the run-out claims, the awarded vendor must provide a separate, per-claim cost for run-in services (see ***Section 5, Cost***).

CorrectCare has included a per-claim run-in cost in its cost proposal.

3.6.3 The vendor shall provide an eligibility exception report of records that do not match the vendor's existing data.

An Eligibility exception report will be provided; however, details will need to be discussed on how to present and reconcile this with the NDOC. Eligibility information will be submitted to Utilization Review weekly as requested.

Exception reports must be reconciled weekly with the NDOC.

The report will be reconciled weekly with NDOC

Eligibility information shall also be forwarded to the Utilization Review Section each week.

Eligibility information will be forwarded to the Utilization Review section each week.

3.6.4 Specify the details of the software system you currently use. Explain the following:

Who wrote the system?

WLT was founded and written by William L. Tiner

When was the system implemented?

WLT was implemented in 1979. CorrectCare has used WLT since 2005. Trisha Back, CorrectCare's claims manager for the Sacramento office, has 13 years' experience working with WLT , including performing the maintenance functions and applying the updates.

When was the system last updated?

The WLT claims system may release updates monthly or quarterly, but no less than annually. The last update release was applied on 8/15/2013.

How are maintenance functions for claims history performed?

Maintenance functions are completed at the end of each month and all completed claims are moved to the history tables within WLT. In addition, claims data is extracted from the claims system 4 times per day and maintained in CorrectCare's reporting database.

How soon after plan changes are implemented is the system is updated to reflect those changes?

Plan changes are implemented in the WLT Claims system with the effective date as requested by the client. Plan changes are real time. As soon as a plan is updated, the change becomes effective immediately.

3.6.5 Explain how checks/drafts, explanations of benefits (EOBs), and/or letters are produced by the system:

Checks, EOBs, and letters are produced by uploading the data into the "Check Write" program. All functions are performed on-site and checks are produced and mailed out as soon as funding is received by the client. Checks can be produced in compliance with the client's needs. In addition, instant checks and EOBs can be produced as needed.

Where are these produced and from where are they mailed?

Checks, EOPs, and denial letters will be produced and mailed from the CorrectCare office in Sacramento, California.

Is the system capable of suppressing the distribution of EOBs and/or letters?

Yes, both EOBs and letters can be suppressed.

How often are checks produced and mailed to providers?

Checks are produced based on a client's desired timeframe. Typically, clients request once per week, but instant checks or EOBs can be produced as needed.

3.6.6 Describe how the system provides diagnosis-related group information, and if it is capable of segmenting hospital charges and length of stay.

The DRG code is captured in a specific field within WLT. This information would be available for reporting either directly from the claim system or from the external database. Hospital charges can be queried for reporting purposes, and CCIH has both claim system and custom reports for Hospital Length of Stay.

3.6.7 Will the system link interim hospital bills processed separately for data reporting and/or analysis?

The system does not link interim hospital bills as they contain different dates and charges. Should we be the successful vendor, CCIH will develop a method for linking these claims through reports extracted from the external database.

3.6.8 Describe the current procedure for overpayment recovery administration and explain how it affects claim history.

Once an overpayment is identified, a refund letter is sent to the provider explaining the overpayment and the amount to be refunded. If there is no response to the first letter, another letter is generated within 30 days and a call to the provider's billing office is made to ensure they received the letter and to answer any questions if necessary. If necessary, we can involve the PPO network if we have difficulty obtaining a refund. Most of their contracts contain language that requires providers to provide appropriate refunds. The claim is adjusted appropriately within the claim system through adjustments or negative transactions.

3.6.9 Describe the procedures for uncashed checks.

For clients on whose behalf we issue checks, a check that does not clear the bank within 180 days is voided and the dollar amount is credited back to the client's claims payment account. The corresponding claim is updated to reflect the change at the time the check is voided.

3.6.10 Can the system issue multiple payments on a single transaction? If so, please describe.

Yes. If a subsequent payment is required on a particular transaction (claim), one or more additional payments can be made through the claim adjustment process. All adjustments associated with the original claim are tracked through a suffix to the original claim number.

3.6.11 Are there maximum and minimum dollar limits on checks issued? If so, please describe.

Typically, for each client group, we determine an amount over which two signatures are required on the check. CorrectCare currently does not have a maximum or minimum dollar amount for checks.

3.6.12 Explain how the system cross-references "Inmates" and "Providers."

Providers can be in one or multiple PPO networks which are set at the Group level and only those PPO networks can be utilized for Inmates within that group. In viewing the inmate's eligibility screen, the PPO network used for the group will be noted. Additionally, the inmate's claim history will list all claims, thus all providers who have submitted claims under his/her group identification number.

3.6.13 Describe the system's audit trails.

WLT uses a "Work Button" to route claims between processor, auditors, and supervisors. The system maintains a history of claim movement. It does not however track what changes were made to the claim. Processors enter change information in the comments fields. An enhancement is in development which will record the comments related to changes within the movement history. In our external database, CorrectCare also records all changes made to a claim and this data is used to create an audit trail.

3.6.14 Are examiners alerted of errors automatically? How are errors rectified?

Processors are notified of errors through the "Work Button". When an auditor or supervisor reviews the claim and detects an error, the claim is automatically routed back to the processor to be corrected. The processor must correct the claim and route it back to the supervisor for final review and release. All employees are assigned to a Supervisor in the WLT system and all claims routed for correction are monitored by the Supervisors to ensure that they are corrected in a timely manner.

3.6.15 Indicate by a "yes" or "no" which positions have the authority to perform the following functions:

Position	**Pay Claims**	**Add/change employees**	**Add/change providers**
Claims manager	***Yes***	***Yes***	***Yes***
Claims supervisor	***Yes***	***No***	***No***
Customer service supervisor	***No***	***No***	***No***
Claims examiner	***Yes***	***No***	***No***

Customer service representative	***No***	***No***	***No***
Provider relations representative	***No***	***No***	***Yes***

3.6.16 Explain how the system automatically identifies duplicate data entries and duplicate claims. Describe the criteria used to edit for duplicates.

The WLT claims system prompts an edit when duplicate entries of inmate identifier information such as social security number or alternate ID number (inmate number) are detected. For duplicate claims, WLT has numerous edits and flags to identify duplicate claims such as "duplicate charge/same provider", "duplicate charge/same procedure", "possible duplicate charge" and "possible exact duplicate". Other duplicate edits include checking individual claim histories within the system, date ranges, provider, matching procedure, revenue code, modifiers and tooth number on dental claims. If the claim is not a true duplicate, then the adjudicator must over-ride the system edit prior to finalizing the claim. The system also allows for denials of duplicate lines within an otherwise paid claim.

3.6.17 Describe how claims are identified in the system. When is the claim ID number assigned and who assigns the claim number? How is the claim ID entered into the system?

Claims are automatically assigned an ID number as they are loaded into the system from 837 files. The ID number consists of the current year, the Julian date, and a unique sequence number for that date.

3.6.18 Explain the cross-reference of continuing claims in the system. Continuing claims refer to multiple visits to different outside providers related to the same condition. It is sometimes necessary to track information/costs related to the multiple visits. For example, if an inmate is attacked by another inmate, the costs of medical care would be charged to the attacking inmate. It is necessary to track all costs of a continuing claim over time and across multiple providers.

A specific episode of care can be tracked in the system through reports based on the date of service range; specific diagnosis code or the authorization code.

3.6.19 Are procedural claim restrictions and dollar limitations provided for in the software program?

Yes - Procedural claim restrictions are set up at the Plan level and dollar limitations are set up at the Group level.

3.6.20 Describe your internal fraud control procedures.

All employees are signed various levels of security based on their position and its responsibilities. Processors can adjudicate claims but cannot enter or change eligibility data, change provider information, or issue checks. Eligibility personnel can enter or change eligibility but cannot process claims, enter providers, or issue checks. Financial personnel cannot enter or change eligibility, enter or change provider information, or process claims.

3.6.21 Explain how group practices, hospital associations, clinics, and other provider groups utilizing the same tax identification are handled by the system.

Group practices, hospital associations, clinics and other provider groups that utilize the same tax identification numbers are assigned provider suffixes under the tax ID number. Those suffixes are identified based on Individual NPI number and address information.

3.6.22 How are preferred providers identified by the system?

Preferred providers are assigned a PPO network code identifying which PPO network they are contracted with.

3.6.23 Describe the type of coding used for the following:

Medical/surgical;
Diagnosis; and
Dental.

During adjudication, claims are edited against industry-standard coding, including but not limited to Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Ambulatory Patient Classification (APC), Diagnosis Related Groups (DRG), Medicare Outpatient Prospective Payment System(OPPS), National Correct Coding Initiative (NCCI), American Dental Association (ADA) and/or any other appropriate revenue codes and modifier edits.

CorrectCare is in the process of testing International Classification of Diseases (ICD-10), with a current CMS implementation deadline of October 2014. Current steps involve the testing of existing systems for the ability to accept and pass the ICD-10 values to other parts of the system and to other systems. CorrectCare plans to complete all ICD-10 testing by the end of 2013

3.6.24 Specify the types of claims on which you require ICD-10th revision and CPT-2013 coding prior to completing processing.

CorrectCare will require ICD-10th revision for UB04 Institutional and HCFA 1500 claims for dates of service provided on or after October 1, 2014 which is the full compliance date for ICD10.

CPT 2013 coding is currently used for 2013 dates of service for UB04 Institutional and HCFA 1500 claims.

What happens when a claim submission does not include a procedure code?

If a procedure code is missing, CorrectCare will process those CPT codes for payment that are listed and deny the line that does not list a CPT code. The EOP will advise that the CPT code must be submitted.

What guidelines are used to differentiate among similarly written descriptions in order to assign an accurate code?

The claims software performs edits based on the code submitted, not the written description.

Are codes entered by claims examiners or special data entry staff? Please explain.

Codes are entered electronically through 837 EDI data files either directly from a clearinghouse or generated from scanned claims.

3.6.25 Please describe your procedure for verification of the accuracy of provider coding.

The WLT claim system applies National Correct Coding Initiative (NCCI) edits and flags any claims for which coding is not accurate for the service or diagnosis. In addition, CorrectCare monitors claims history through specific reports for up-coding and/or other trends.

3.6.26 Describe your quality review procedures and how claims are selected for review:

What percentages of claims per examiner and per data entry clerk are reviewed on a daily basis to ensure accuracy of payment?

Pay limits are set within the system. New processors are put on a $0 hold (every claim processed will stop and be reviewed for accuracy). After 90 days, depending on weekly & monthly accuracy reports, the pay limits will be increased. The pay limit is reviewed monthly and will increase or decrease based on monthly accuracy reports.

Random audits are performed on a monthly basis. Each month 3-4% of each processor's claims are reviewed for accuracy.

Can the percentage be increased upon client request?

Yes

3.6.27 Describe how your quality review result reports produced.

How frequently and under what circumstances?

Reports are submitted weekly to each processor with the number of claims processed during that week and the number/types of errors. Reports are submitted monthly to each processor with total number of claims audited during that month with total number of errors and given a monthly accuracy rate (the goal is to be at 98%). Random audit reports are done by month, by individual processor.

Are the results maintained by individual? By client? By office?

Results are maintained by individual processor within each individual client.

How are results used?

Results are used to improve our internal processes and help focus on areas in need of additional training.

3.6.28 What is the ratio of quality reviewers to claim examiners?

CorrectCare's ratio of quality reviewers to claims examiners is 1:4

3.6.29 Please describe your review process. What triggers review by a higher supervisory authority?

Claims are reviewed for accuracy in payment and data entry (verifying information on claim image is accurately carried over into the claims processing system) on a daily basis, pre-payment. High dollar claims are reviewed in a pre-payment audit for accuracy on a daily basis. Random audits are reviewed for accuracy on a monthly basis post-payment.

3.6.30 What types of internal audits are in place to monitor claims administration, e.g., Internal Audit, Quality Assurance, Corporate Review? What is the frequency and who performs them?

Quality Assurance audits are conducted on a daily basis. These include random sampling audits, new processer audits, over-operator limit audits, and high dollar claim review. In addition, daily, executive leadership reviews all claims statistics such as inventory, age, pend status, and more. Annually, CorrectCare retains an outside auditor that reviews claims administration and funding account practices as well as all other lines of business. The auditing firm is changed at least every 3 years to assure continued quality and objectivity.

3.6.31 Please explain how you will measure or review quality within your office for the unit handling the State.

CorrectCare initially sets each processor at a $0 hold, reviewing all claims processed on a daily basis for clerical & payment accuracy.

After 90 days, each processor will be reviewed on quality and pay limits will be increased as necessary.

Weekly reports will be generated for each individual processor stating the number of claims audited and the number of errors for that week.

A monthly report will be generated for each individual processor stating the total number of claims audited for that month with the total number of errors (the goal is to be at 98% accuracy). Pay limits will be increased/ decreased monthly based on accuracy rates.

3.6.32 Please complete the following for the office that will process the State's claims and submit documentation in support of your responses.

Calendar Year		**Claim Processing Accuracy (number of claims)[2]**			
	Financial Payment Accuracy (Dollars)[1]	**Payment Accuracy Rate**	**Procedural Accuracy Rate**	**Coding Accuracy Rate**	**Overall Accuracy Rate**
2011 Objectives	**98%**	**98%**	**98%**	**98%**	**98%**
2011Results	**99.98% ($5,118,358.62)**	**98.79%**	**99.98%**	**99.98%**	**98.34%**
2012 Objectives	**98%**	**98%**	**98%**	**98%**	**98%**
2012 Results	**99.99% ($5,568,165.68)**	**99.45%**	**99.99%**	**99.99%**	**98.38%**
2013 Objectives	**98%**	**98%**	**98%**	**98%**	**98%**
2013 YTD	**99.99% ($4,417,766.58)**	**99.85%**	**99.99%**	**99.99%**	**99.07%**
2014 Objectives	98%	98%	98%	98%	98%
2014 Results YTD					

[1] Percentage of audited dollars paid accurately = overpayments plus underpayments divided by the audited paid dollars (do not subtract underpayments from overpayments).

3.6.33 Explain how claim inventory (unprocessed claims) is monitored and managed.

Currently, CorrectCare's claims database automatically generates work lists at specific timeframes and sorts non-completed claims by age, type, and pend reason, if any. First line supervisors distribute the work lists according to age. Claims managers for the associated group review the status throughout the day and provide daily status reports to Corporate Management.

CorrectCare will be phasing in an enhanced workflow management software over the next 18 months. The new system will replace the automated worklists by automatically populating processers work queues with the next claim to be completed. Managers will then monitor progress and productivity in real time.

3.6.34 Describe how turnaround time (TAT) is monitored and managed.

TAT is both managed and monitored through daily automated work lists. Each claim on the work list includes the age if unadjudicated or pended, and the age plus days since adjudication if adjudicated. All work lists are ordered by age, oldest claims appearing first on the list. Managers monitor and update work lists throughout the day so that older claims, once adjudicated, can be reviewed and released by an auditor that same day.

What are your claim TAT standards?

CorrectCare's TAT standards are generally client specific. For example, one client requires 98% of claims submitted for payment within 28 days. In the absence of a specific TAT requirement, CorrectCare's standard is 98% of clean claims processed within 30 days.

Will you be able to provide computer-produced reports at no additional charge to the State that document your TAT on the NDOC claims? Please provide a sample report on CD.

Yes, automated reports that document TAT will be produced and available at no additional charge. A sample TAT report is provided on the CD.

3.6.35 Explain measurement of your TAT.

When are claims considered "processed" for turnaround measurement purposes?

For clients on whose behalf we issue payment, claims are considered processed for turnaround time when the claim is presented to the client on a payment file or register. For clients who issue their own checks, claims are considered processed when sent to them for payment.

When is a claim considered received?

A paper claim is considered received based on the scan date plus one. CorrectCare scans all claims the actual date of receipt and converts to an EDI file, which is uploaded the following day. For electronic claims, the date received is the date the EDI file is received from the clearinghouse.

3.6.36 Explain how the following claims are treated when measuring TAT:

Processed without delay;
Internal office referrals;
External home office referral; and
Pended claims (awaiting receipt of additional information).

All claims processed are currently included in TAT calculations. Starting in 2015, CorrectCare will have new definitions for TAT for clients served from Sacramento office; therefore, calculations will be modified to exclude non-clean claims.

3.6.37 Please complete the following for the office that will process the NDOC's claims.

Turnaround Time **	**Percent of Claims Processed**	
	In 0-14 calendar days	In 0-30 calendar days
2011 Objective		***98% in 28 calendar days***
2011 Results	***59.79%***	***99.00%***
2012 Objective		***98% in 28 calendar days***
2012 Results	***58.95%***	***99.21%***
2013 Objective		***98% in 28 calendar days***
2013 Results	***76.92%***	***99.89%***
2014 Objective		***98% in 28 calendar days***
2014 Results YTD	***N/A***	***N/A***

TAT is calculated from date of receipt until date adjudicated/finalized. All claims, including non-clean claims, were used in TAT calculations for the above results.

3.6.38 Please specify any performance guarantees that you are offering that differ from those set forth in ***Section 3.10*** regarding the following:

Payment accuracy;

Claim processing accuracy;

Turnaround time;

Customer service accessibility (average speed of answer, hold time, abandonment rate); and

Overall account management.

3.6.39 Please describe in detail your proposed performance standards, guarantees, method of measurement and amount at risk. Include in your proposal a sample report

available to verify your performance. This report is subject to audit and verification by the State. Your response to this section should be submitted with ***Section 3.10***.

CorrectCare acknowledges and agrees to the Service performance Standards set forth in Section 3.10, Descriptions of those Standards, Guarantee percentages and Penalty amounts. However, CorrectCare would like to propose an option of submitting claims for funding twice per week instead of only once. This would prevent some claims from aging up to an additional week once adjudicated. Actual audit results are included in the "Other Informational Material" section, tab 9.

3.6.40 Describe the claim processing workflow from point of claim receipt to issuance of a claim draft.

CCIH receives claims electronically (EDI) via 837 files both directly from a clearinghouse and from PPO networks. We received over 500,000 EDI correctional claims from our clearinghouse in 2012. EDI claims currently represent greater than 62% of our total claims volume. Paper claims are scanned and submitted for conversion to EDI (OCR) the same day they are received. Converted EDI files are returned the following day and loaded into the claims system. All scanned claim images are archived, and a claim image is created for all EDI claims. Claim images are indexed by image number assigned during conversion, the EDI reference number, and the CCIH claim number. All images are available for viewing as desired.

All claims go through a series of states prior to being finalized. These include initial validation, eligibility checks, incorporation of authorizations, validation of provider contracts and fee schedules, initial edits, secondary edits, application of pricing, and finalization. Once adjudicated, a fund-lock and subsequent funding request is created. Checks are issued within 24 hours of the claims account being funded. A diagram of the CCIH claims flow process is located in tab 9, Other Informational Material.

3.6.41 Describe your procedures for tracking pended claims.

Are they maintained on the system?
Are periodic status reports generated?
When is a claim considered "closed"?

All pended claims are maintained in the system and appear on daily work lists along with their age and pend/reason code. Claims are only pended for information from the client and/or for supervisory review or another internal process from CorrectCare, such as update of a provider record. Claims requiring further information from the provider are denied and returned to the provider with a request for the information. Therefore, a claim is considered closed once it is adjudicated and paid or denied.

3.6.42 What procedure do you use to handle services delivered that were not pre-authorized by the client?

Claims for services not authorized by the client can be pended as an exception for review by the client or its review agent and/or the claim can be denied and returned to the provider. A retro review can be offered if the client's plan document allows for such. CorrectCare currently has clients using both the exception process and retro reviews.

3.6.43 Please indicate the percentage of automation for the items listed below, according to the following categories:

Automated: The data is accessed and adjudicated automatically by the computer in processing the claim.

Mixed: Data is accessed by the processor and manually entered into the computer, which then completes processing.

Manual: Data is accessed by the processor and processor completes the benefit calculation. Computer not involved or involvement limited to updating claim history.

Claim Processing Procedure	% Automated	% Mixed	% Manual
Provider verification	*100*		
Eligibility verification	*100*		
Plan specifications	*100*		
Current	*100*		
Prior	*100*		
COB data		*100*	
Duplicate bills	*75*	*25*	
Negotiated reimbursements			
Per diems	*100*		
Per case	*50*		*50*
Per DRG		*100*	
Physician fee schedules	*100*		
Discount off charges	*100*		

3.6.44 Describe your techniques for identifying and resolving questionable provider billing practices, including "unbundling" of services.

In addition to reviewing provider and group-level reports on denial reasons, CorrectCare uses Verisk Clinical Rules Solutions to further identify questionable provider billing practices such as unbundling and/or up-coding. CorrectCare's edits assure that comprehensive and new patient procedure codes are only used according to appropriate guidelines and timeframes.

3.6.45 Briefly describe the system documentation requirements (procedures and timing) for other coverage information.

Other Coverage Information is entered into the Eligibility screen in the WLT claims system. This screen indicates the start and end date for the other coverage. When the eligibility record has other coverage indicated and claims are processed,

the primary carrier payment amount is entered into the processing screen from the Primary EOB received with the claim. The system then will calculate the secondary payment.

3.6.46 How do you investigate for potential workers' compensation claims?

Most information regarding potential workers' compensation comes from utilization management data for our existing clients. When a request is made for service, contributing history is part of the information requested. Should that history include any information about an injury prior to incarceration, workers compensation responsibility is then investigated.

3.6.47 How do you investigate for potential subrogation or other third-party liability claims?

Currently, CorrectCare primarily investigates subrogation or third party liability on claims for services that are potentially Medicaid eligible. If the claims was previously paid, a refund is requested and the claim is then filed with the appropriate third party payer. If we are providing prior authorization and/or concurrent reviews through our utilization management services, we can investigate through their clinical information on the accident/injury. Whenever third party liability is determined, the information regarding the payer is tied to the authorization.

3.7 OVERPAYMENT PROTOCOL

3.7.1 The vendor must credit back to the State any recovered overpayments. All accumulators must be updated accordingly. In the event the vendor's company is responsible for an overpayment that cannot be recovered, the vendor must agree to indemnify the State for the full amount of the overpayment.

CorrectCare acknowledges and agrees to the above requirement.

3.7.2 The vendor's claim system must "remove" overpayments from the system and all affected reports at the time the overpayment is identified. All online accumulators and payment reports must be updated to reflect the amount that should have been paid.

CorrectCare acknowledges and agrees to the above requirement.

3.7.3 The following requirements apply to identification of mispayments.

The awarded vendor shall randomly audit not less than 4% of daily processed claims.

The awarded vendor shall log and account for all mispayments found from internal audit and other sources.

The NDOC may require additional audits, including, but not limited to, quality control audits by the NDOC and/or other contracted auditors at the contracted vendor's expense.

All mispayments in excess of $3,000 will be reviewed by the awarded vendor's supervisory personnel and reported to the NDOC on a monthly basis at the time the mispayment is identified.

CorrectCare acknowledges and agrees to the above requirements.

3.7.4 The following requirements apply to mispayment correction.

Underpayments will be adjusted or reimbursed to the appropriate payee in a reasonable time after discovery.

Unless the payee's PPO or provider agreement allows for set-off adjustment of overpayments against any outstanding claim, overpayments will only be adjusted out of those other claims that are from the same provider in the same State of Nevada fiscal year.

The awarded vendor's overpayment log shall include all collection history, including phone collection efforts.

Within 10 days after discovery, the awarded vendor shall provide the payee with a written notice of overpayment and request for reimbursement.

After 30 days of non-payment after the first notice, the awarded vendor shall provide the payee a second written notice of request for reimbursement.

After 45 days of non-payment after the first notice, the awarded vendor will refer the matter back to the NDOC to pursue collection in accordance with NRS Chapter 353C via the State Controller's Office.

The awarded vendor's collection agency must comply with state and federal debt collection laws, and its fees shall be at the successful vendor's expense. If overpayment or mispayment was made due to NDOC staff direction or approval, the fees shall not exceed 20% of the amount collected without obtaining prior approval from the State.

The awarded vendor shall require regular reporting by its collection agency that will be shared with the NDOC.

Neither the awarded vendor nor its collection agency may bring legal action against a provider to collect an overpayment.

Any unsuccessful collection matter that requires legal action shall be referred to the NDOC for assessment and consultation with the Office of the Attorney General.

The awarded vendor shall internally audit the mispayment logs, and make both the logs and any internal audit report available to the NDOC's auditors upon request.

CorrectCare acknowledges and agrees to the above requirements.

3.8 CLAIMS EXAMINER SPECIFICATIONS

3.8.1 Describe the required minimum qualifications to be employed by your company as a claim examiner.

Are prospective employees required to possess training in medical terminology?

Yes

Are prospective employees required to possess training in the coding and interpretation of information on medical bills?

Yes, all claims processors must have 3-5 years' experience in claims processing, including experience in coding and the interpretation of information on the medical claim.

Describe your internal claim examiner training, program content, timing, and performance requirements.

New employees have a 90 day period to become familiar with the WLT claims processing system. Orientation is provided on a one-to-one basis, one claim type at a time, until the examiner is familiar with our system. One hundred percent of a new employee's claims are audited during this time period. Performance standards are based on both quality and quantity. A daily productivity quota is set for each processor based on the type of claim and the group requirements. All claims processors are required to maintain 98% accuracy on a monthly basis. Any who fall below 98% have their dollar limits lowered and/or are returned to 100% audit until they reach 98%. Should they not return to 98% percent accuracy in a three month period, their employment is terminated.

What is the average length of employment for examiners who will handle the NDOC's claims?

The average length of employment for claims processors in our Sacramento office is 3 years. This office was established in 2009,

and more than half the staff has been employed since the office opened. Additional staff was added in years two and three based on volume increases. All claims processors are required to have 3-5 years previous claims processing experience before joining CorrectCare.

What is your employee turnover rate in the past 12 months in the claims area for the office that will handle the NDOC's claims?

In the last 12 months ending November 2013 the turnover rate has been 33%. In the prior year it was 12%. The California office has had 8 employees leave throughout 2013. One employee was separated due to unsatisfactory work performance, two requested extended medical time off which we could not grant due to our business needs and the other five left for positions that offered higher hourly rates and flexible work hours and/or the ability to work from home.

Once our company was informed of the reasons these employees were leaving, we (1) gave an across the board increase to all hourly employees and (2) changed the office hours to create a more flexible work schedule. The office is currently open from 6:00am – 6:00pm allowing employees a flexible work day.

Are claim production incentives utilized? What is the expected productivity level for medical claims? (Distinguish between claim examiners and data entry personnel.)

Productivity for medical claims processors is 120 per day. However, as experience is established, that number can increase or decrease depending on the type of work assigned.
Data entry staff typically enters claim information into a DRG grouper and/or OPPS pricing tools. The productivity expectation is 100+ claims per day. Mailroom staff scans 2000+ claims per day.

Include sample company policy manuals with your proposal.

A sample company policy manual for claims processing is included in the proposal under tab 9, Other Informational Material

Include a list of resource tools used by claims examiners. Indicate tools provided to examiners on their desks and those located in a central location.

CorrectCare uses the Trilogy Claims Administration manual as a resource for Industry Standards. Claim examiners also have access to past and current years of CPT, ICD9 & 10 work books, RedBook on line to research Drugs and NDC numbers also CMS/

Noridian to research policy and procedures. CorrectCare also has access to Verisk's Clinical Rules Solutions to defend any edits applied to a claim. All resources are available online and/or in a central location for all to use.

Is the vendor's claim system able to adjudicate claims based Medicare rates in the event that reimbursement rates are predicated on Medicare rates?

Yes, CorrectCare currently processes claims for several clients using Medicare-based rates. CorrectCare has created and maintains a CMS pricing tool that accesses zip code specific pricing from data published on the CMS website.

3.9 CUSTOMER SERVICE

3.9.1 Is Customer Service administered by a separate unit?

Customer Service is administered by the same unit/employees that are processing the claims.

3.9.2 What claims history information may a customer service representative access in response to an inquiry on processed and pending claims?

Customer service representatives have access to the complete claim history for processed and pending claims.

3.9.3 Please describe how customer service inquiries are monitored.

Customer Service inquiries are logged into Call tracking module in the claims system. The calls are linked to the inmate eligibility records and the history can be accessed by all the representatives taking calls. The system produces Call tracking reports that will show all calls, those that are Resolved versus Unresolved, and all call information that was recorded at the time of the call. Supervisors monitor these reports on a daily basis.

3.9.4 Do customer service representatives process adjustments to claims online? Is the claim system updated immediately? How do the customer service representatives interact with your claims system to handle claim inquiries?

Customer Service representatives do not process adjustments to claims. When a call is received that requires an adjustment to be completed, the call is routed to the Supervisor or a dedicated processer for adjustments/refunds, who completes the adjustment. The system is updated at the time of the adjustment.

Customer service representatives log all claim inquiries into the call tracking system and have the capability to route the calls and claims if the claim requires additional research and/or an adjustment.

3.9.5 Describe how and when customer service representatives interact with the claims examiners.

CorrectCare selects certain claims processers to be cross trained to act as customer service representative as well, so they have a thorough understanding of the processing procedures. For most groups, one or more processers are designated as the customer service representatives, so other processers are strictly focused on adjudication of claims.

3.10 PERFORMANCE STANDARDS AND GUARANTEES

3.10.1 Service Performance Standards

In addition to the general and special damages that may result from a breach, the measure of damages to daily State operations in the event of a failure of performance by the awarded vendor may be difficult or impossible to calculate, depending on the nature of the default. In the event the awarded vendor fails to perform services or complete deliverables in accordance with the response times required in this RFP, or as specified or negotiated in the successful proposal, additional performance guarantee liquidated damages may be calculated with or without declaration of default or breach.

The following requirements are areas wherein the awarded vendor will guarantee performance. Failure to meet the required standards will result in the assessment of liquidated damages. Liquidated damages will be enforced by reducing a percentage of the administrative fees due to the awarded vendor. Prompt resolution of problems or issues is expected, but will not reduce or eliminate any liquidated damages imposed due to failure to meet the performance standards outlined below. Proposing vendors should indicate other guarantees they you are willing to include as part of the contract.

Service Performance	Description	Guarantee
Claims financial error rate	The dollar amount of claims paid accurately divided by total dollars paid.	***99%***
Turnaround time (TAT) of claims processed	Claims processed within 14 working days.	***90%***
Data Reporting	(a) Deliver standard reports within 10 days of end of reporting period (b) Deliver annual reports & regulatory documentation within 10 days of policy year-end.	***100%*** ***100%***
Payment	Penalties shall be paid before ninety (90) days from the end of the quarter	***100%***

3.10.2 Service Performance Penalties

Liquidated damages will be enforced by a measured guarantee. Prompt resolution of problems or issues is expected but will not reduce or eliminate any liquidated damages imposed due to failure to meet the performance standards.

Service Performance Standard	Description	Penalty
Claims financial error rate	The dollar amount of claims paid accurately divided by total dollars paid.	***20% of Administrative fees***
Turnaround time (TAT) of claims processed	Claims processed within 14 working days.	***20% of Administrative Fees***
Implementation	(a) Task(s) completed on time (b) Problem resolution – problems documented within two business days and resolution within 10 business days	***20% of Administrative Fees***
Data Reporting	(a) Deliver standard reports within 10 days of end of reporting period (b) Deliver annual reports, regulatory documentation within 10 days of policy year-end.	***20% of Administrative fees***

In their proposals, vendors should submit a chart similar to the one shown above with proposed Performance Guarantees and Fee Reduction rates. Vendors should describe in detail their proposed performance standards, guarantees, method of measurement, and amount at risk. Include in the proposal a sample report available to verify performance. This report is subject to audit and verification by the State.

CorrectCare acknowledges and agrees to the above Service performance Standards, Descriptions of those Standards, Guarantee percentages and Penalty amounts. However, CorrectCare would like to propose an option of submitting claims for funding twice per week instead of only once. This would prevent some claims from aging up to an additional week once adjudicated.

For clean claims, TAT for NDOC will be measured from date of receipt, defined as scan date, until date presented to NDOC for funding. Claims that are pended for additional information from NDOC or the provider will be exempt from TAT calculation during the time it takes to receive the information. Once all information is received, the clock will resume.

The claims financial error rate is calculated as described above, the dollar amount of claims paid accurately divided by total dollars paid.

A TAT sample report is included in the appendix and a report on audit statistics, including financial error rate is also included.

Section 4 – Company Background and References

4. COMPANY BACKGROUND AND REFERENCES

4.1 VENDOR INFORMATION

4.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	***CorrectCare-Integrated Health, Inc.***
Ownership (sole proprietor, partnership, etc.):	***Privately-held Corporation***
State of incorporation:	***Commonwealth of Kentucky***
Date of incorporation:	***September 9, 1996***
# of years in business:	***17 years***
List of top officers:	***Art Hellebusch, Chairman / Owner; Dr. Anthony Baxter, CEO / Owner; Linda Goins, President; Jim Burkhardt, Chief Operating Officer; Art Hall, Chief Information Officer; Jenny Kahler, Secretary / Treasurer***
Location of company headquarters:	***366 South Broadway, Lexington, KY 40508***
Location(s) of the company offices:	***366 South Broadway, Lexington, KY 40508; 1218 South Broadway, Lexington, KY 40504; 600 North Market Blvd., Suite 4, Sacramento, CA 95834***
Location(s) of the office that will provide the services described in this RFP:	***600 North Market Blvd., Suite 4, Sacramento, CA 95834***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***None in Nevada***
Number of employees nationally with the expertise to support the requirements in this RFP:	***CA: 24 processors and claims support personnel. KY: 15 processors and claims support personnel plus 7 IT employees that support the claims processing system and 4 administrative personnel providing oversight and claims account / payment responsibilities.***
Location(s) from which employees will be assigned for this project:	***600 North Market Blvd., Suite 4, Sacramento, CA 95834***

4.1.2 **Please be advised**, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

Certificate # C20131028-1617 (included in the appendix)

4.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Question	Response
Nevada Business License Number:	***NV20131631138***
Legal Entity Name:	***CorrectCare-Integrated Health, Inc.***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	***X***	No	

If "No", provide explanation.

4.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

CorrectCare Integrated Health is appropriately licensed.

4.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	***X***

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

4.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person will be performing or producing the services which you will be contracted to provide under this contract, you must disclose the identity of each such person in your response to this RFP, and specify the services that each person will be expected to perform.

4.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

Question	**Response**	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

4.1.8 Vendors must review the insurance requirements specified in ***Attachment E, Insurance Schedule for RFP 3086.*** Does your organization currently have or will your organization be able to provide the insurance requirements as specified in ***Attachment E.***

Yes	***X***	No	

Any exceptions and/or assumptions to the insurance requirements ***must*** be identified on ***Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP.*** Exceptions and/or assumptions will be taken into consideration as part of the evaluation process; however, vendors must be specific. If vendors do not specify any exceptions and/or assumptions at time

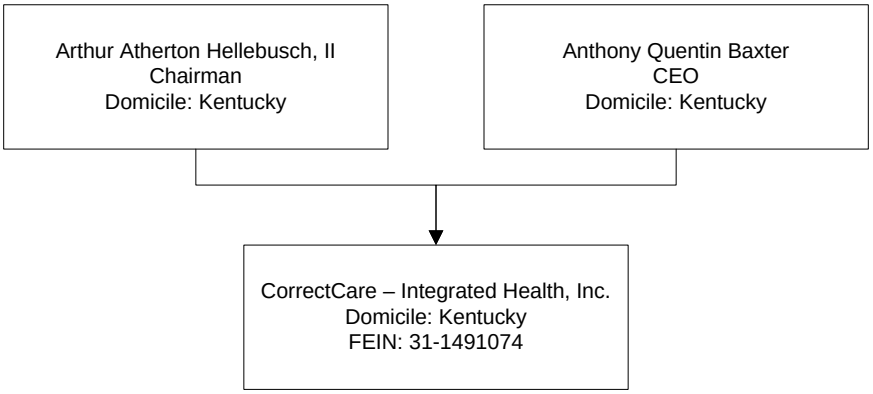
of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

Upon contract award, the successful vendor ***must*** provide the Certificate of Insurance identifying the coverages as specified in ***Attachment E, Insurance Schedule for RFP 3086.***

4.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

CorrectCare – Integrated Health (CCIH) is a correctional-specific provider of third party administrative (TPA) services – claims processing, utilization management, and preferred provider (PPO) network access. Through our extensive experience with elements unique to the correctional industry, CCIH tailors its claims management and support processes to meet individual client needs.

CorrectCare - Integrated Health's principal location of business is 366 South Broadway, Lexington, Kentucky 40508. A satellite office is located at 600 North Market Boulevard in Sacramento, California. The company's ownership structure is as follows:



The company is structured as a Subchapter "S" Corporation. The company's stock is wholly owned by Anthony Baxter and Arthur Hellebusch, each with 50% ownership. There are no affiliated entities or other legal entities such as divisions

Early in our history, the decision was made to focus on medical management for correctional clients - initially utilization management and handling of claims for third party providers. By integrating commercial practices with correctional specific elements, CCIH has developed expertise in the areas of claims processing, provider networks, utilization review, risk management, auditing, recovery, and case management for our clients.

Since 2003, our company has provided claims processing, utilization management, and provider network access solely within the correctional environment beginning with the Kentucky Department of Corrections. And, in 2004, CCIH began staffing medical departments within KYDOC correctional

facilities. In that same year, CCIH implemented the MedUnison DocSynergy™ electronic medical system in all KYDOC institutions within seven months. In November 2005, all medical related contracts that the KYDOC maintained (onsite services such as Dental, Pharmacy, Optometry, Physical Therapy, Laboratory, Radiology, Dialysis, etc.) were placed under the company's responsibility to administer and manage. Finally, in July 2007, as requested by the Kentucky legislature and the KYDOC, we expanded our commercial provider network and medical bill adjudication and re-pricing to the majority of the 78 county and regional jails in Kentucky.

For nearly ten years, CCIH has had the medical services contract with the KYDOC – first through the University of Kentucky and most recently since January 1st, 2013 directly with the KYDOC.

In June 2009, CCIH began processing medical claims for California Correctional Health Care Services (CCHCS), which has the largest inmate population in the nation. This initial two-year contract has been renewed twice and most recently extended through the end of June 2015.

In addition to our contract with the KYDOC and CCHCS, CCIH has provided and/or currently provides services to other correctional clients as detailed below.

From November 2004 through June 2008, CCIH offered its TPA services to county jails as well. In Kentucky we worked with Calloway, Campbell, Grant, Grayson, Kenton, and Woodford counties. Following legislation passed in 2007 (KY House bill 191), individual county contracts were no longer necessary as the State covered our fees on behalf of the counties; we provide these services to all county jails, now, directly through our contract with the State.

From May 2005 through September 2009, we processed all claims and issued checks to providers for three Corrections Corporation of America (CCA) facilities in Kentucky. Electronic Medical Record access was also provided to those facilities and continued to be provided to one facility up until September 2013 when the facility stopped housing Kentucky inmates.

The Ohio Department of Rehabilitation and Corrections (ODRC) has also been a client. We began re-pricing claims at Medicaid rates for inmates in eight state institutions starting in June 2006. In fiscal 2008, this contract was renewed and expanded for a total of 31 institutions (40,000 offenders). We held this contract until May 2010. We still have some business in Ohio re-pricing claims for two regional jails.

In 2012, CorrectCare also started providing claims adjudication, network access and utilization management services to Conmed Healthcare Management. Currently, utilization review services encompass four jail facilities with a total population of approximately 1,500 inmates located in Texas, Oregon, New Jersey and Washington while TPA services are provided to three jail facilities in Texas and New Jersey.

CorrectCare also adjudicates inmate claims for Prime Health Services (Brentwood, TN) for its contracts with Baldwin County, Alabama and numerous county jail facilities in North Carolina and Florida.

In April of 2013, CorrectCare was awarded the contract for TPA services for the Louisiana Department of Public Safety and Corrections. CorrectCare began adjudicating medical claims for 55,000 offenders in both State Prisons and Parrish Jails on July 1.

Also in 2013, CorrectCare began providing: (1) utilization review and claims processing services for Lassen and Mariposa Counties in California and Hancock County, Tennessee; and (2) claims processing services for another four counties – Vanderburgh, Indiana, Del Norte, CA and Sumner and Sequatchie, Tennessee.

Please note that CCIH has never had a contract cancelled for lack of performance; however, we did have contracts with Corrections Corporation of America (CCA) and the Ohio Department of Rehabilitation and Corrections (ODRC) that were ended for other reasons. CCA consolidated all network and TPA services with a national vendor, and the ODRC combined TPA services with utilization management and the contract was retained by the incumbent utilization management firm.

4.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

As noted above, CorrectCare has provided TPA services to correctional clients for 10 years. Currently we cover over 200,000 inmate lives and process 3,000-5,000 claims per day. All claims processing and subsequent edits are based on CMS (Medicare) standards and guidelines.

4.1.11 Financial information and documentation to be included in ***Part III, Confidential Financial Information*** of vendor's response in accordance with ***Section 9.5, Part III – Confidential Financial Information***.

4.1.11.1 Dun and Bradstreet Number ***08-551-3369***
4.1.11.2 Federal Tax Identification Number ***31-1491074***

4.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement
B. Balance Statement

This information has been included in Part III – Confidential Financial Information per the Section 9.5 instructions.

4.2 SUBCONTRACTOR INFORMATION

4.2.1 Does this proposal include the use of subcontractors?

Yes		No	X

If "Yes", vendor must:

4.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

4.2.1.2 If any tasks are to be completed by subcontractor(s), vendors must:

A. Describe the relevant contractual arrangements;

B. Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

C. Describe your previous experience with subcontractor(s).

4.2.1.3 Vendors must describe the methodology, processes and tools utilized for:

A. Selecting and qualifying appropriate subcontractors for the project/contract;

B. Ensuring subcontractor compliance with the overall performance objectives for the project;

C. Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

D. Providing proof of payment to any subcontractor(s) used for this project/contract, if requested by the State. Proposal should include a plan by which, at the State's request, the State will be notified of such payments.

4.2.1.4 Provide the same information for any proposed subcontractors as requested in ***Section 4.1, Vendor Information***.

4.2.1.5 Business references as specified in ***Section 4.3, Business References*** must be provided for any proposed subcontractors.

4.2.1.6 Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

4.2.1.7 Vendor must notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in ***Section 4.2, Subcontractor Information***. The vendor must receive agency approval prior to subcontractor commencing work.

4.3 BUSINESS REFERENCES

4.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.

4.3.2 Vendors must provide the following information for ***every*** business reference provided by the vendor and/or subcontractor:

The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

Reference #: 1	***CPHCS Agreement Number ICHC.08774—TPA Medical Claims Processing Services Agreement***		
Company Name:	***California Correctional Health Care Services***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	***Mr. David Hale***		
Street Address:	***8260 Longleaf Drive***		
City, State, Zip	***Elk Grove, CA 95758***		
Phone, including area code:	***(916) 691-2597***		
Facsimile, including area code:	***none***		
Email address:	***David.Hale@cdcr.ca.gov***		
Alternate Contact Information			
Name:	***Ms. Karen Creighton***		
Street Address:	***8260 Longleaf Drive***		
City, State, Zip	***Elk Grove, CA 95758***		
Phone, including area code:	***916-691-5749***		
Facsimile, including area code:	***916-691-3940***		
Email address:	***Karen.Creighton@cdcr.ca.gov***		
Project Information			
Brief description of the project/contract and description of	***Adjudication of inmate medical claims for all CDCR adult and juvenile***		

services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***institutions. Multiple interfaces to other agencies/vendors including State Controller's Office, BIS Accounting System, and Medi-Cal.***
Original Project/Contract Start Date:	***April 8, 2009 for 24 months with 3 additional one-year terms***
Original Project/Contract End Date:	***With all extensions the contract would have ended April 8, 2014. However, we have already received an additional extension through June 30, 2015.***
Original Project/Contract Value:	***$14.4MM (2 years) increased to $63.4MM with all extensions***
Final Project/Contract Date:	***Currently ongoing with final date of June 30, 2015.***
Was project/contract completed in time originally allotted, and if not, why not?	***Project is ongoing with expectations being met or exceeded.***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Yes. Project is under budget. We have invoiced approximately $31MM through October 2013.***

Reference # 2:	***SFO No. 400PUR087/278—Third Party Administrator for Offender Health Claims***		
Company Name:	***Louisiana Department of Public Safety and Corrections (DPS&C)***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:		***Ms. Melissa Steib***	
Street Address:		***504 Mayflower, P.O. Box 94304***	
City, State, Zip		***Baton Rouge, LA 70804***	
Phone, including area code:		***(225) 342-6553***	
Facsimile, including area code:		***(225) 219-9354***	
Email address:		***msteib@corrections.state.la.us***	
Alternate Contact Information			
Name:		***Ms. Stacy Brown***	
Street Address:		***504 Mayflower, P.O. Box 94304***	
City, State, Zip		***Baton Rouge, La 70804***	
Phone, including area code:		***(225) 342-6543***	
Facsimile, including area code:		***(225) 219-9354***	
Email address:		***staceybrown@corrections.state.la.us***	
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software		***Third Party Administrator (claims adjudication and payment) for offenders under the custody of the DPS&C, as well as offenders housed in***	

applications, data communications, etc.) if applicable:	***local correctional facilities, and offenders in the custody of the Office Of Juvenile Justice. WLT Software is used to adjudicate claims.***
Original Project/Contract Start Date:	***July 1, 2013***
Original Project/Contract End Date:	***Ongoing***
Original Project/Contract Value:	***$992,880 maximum for 9 months***
Final Project/Contract Date:	***March 31, 2013 with one 3 month renewal option.***
Was project/contract completed in time originally allotted, and if not, why not?	***The project is still ongoing with the implementation on schedule.***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Yes. Project is currently within budget.***

Reference #3:	***PON2 527 1300001272 1—DOC Inmate Medical and Dental Services***		
Company Name:	***Kentucky Department of Corrections (KYDOC)***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:		***Ms. Cookie Crews***	
Street Address:		***2605 West Hwy 146***	
City, State, Zip		***LaGrange, KY 40031-9742***	
Phone, including area code:		***(502) 526-7259***	
Facsimile, including area code:		***(502) 222-7895***	
Email address:		***cookie.crews@ky.gov***	
Alternate Contact Information			
Name:		***Dr. Douglas Crall, M.D.***	
Street Address:		***2605 West Hwy 146***	
City, State, Zip		***LaGrange, KY 40031-9742***	
Phone, including area code:		***(502) 222-7808***	
Facsimile, including area code:		***(502) 222-7895***	
Email address:		***Doug.Crall@ky.gov***	
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:		***Claims administration, utilization management and PPO network access for state inmates in state facilities and county jails. Services were later expanded to include county inmates as well as medical staffing, medical contract management and provision of an EHR in state facilities. Claims***	

	adjudication is performed using WLT Software
Original Project/Contract Start Date:	***October 2003 through the University of Kentucky***
Original Project/Contract End Date:	***Extensions and a renewal through the RFP process took the contract through 12/31/12.***
Original Project/Contract Value:	***$383,088,000.***
Final Project/Contract Date:	***Contract went direct with the KYDOC from 1/1/13 to 12/31/13. Our contract to be extended due to award protest.***
Was project/contract completed in time originally allotted, and if not, why not?	***Yes***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Some budget overages when contract was through the University of Kentucky due to staffing and related medical service additions that were requested by the KYDOC, increases in inmate population as well as claims dollars exceeding their estimates. Current calendar year contract with the KYDOC estimated to be $53.4MM compared to $56MM contract value.***

4.3.3 Vendors must also submit ***Attachment F, Reference Questionnaire*** to the business references that are identified in ***Section 4.3.2***.

Attachment F has been provided to all the business references identified above.

4.3.4 The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.

Instructions were given to the business references to submit directly to the Purchasing Division

4.3.5 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in ***Section 8, RFP Timeline*** for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.

Acknowledged

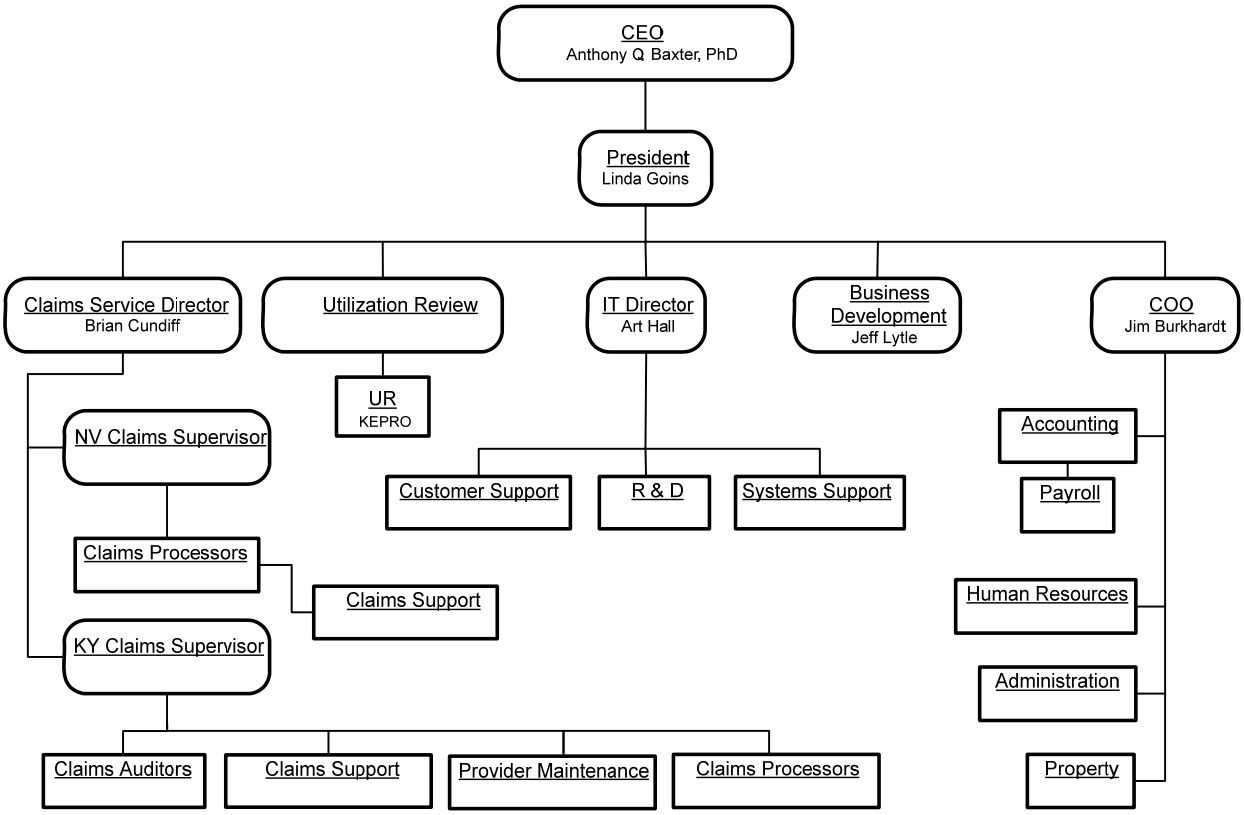
4.3.6 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

Acknowledged

ATTACHMENT G – PROPOSED STAFF RÉSUMÉS

ORGANIZATION CHART

Below is an organization chart showing our organization. Résumés of key individuals follow.



PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	*CorrectCare – Integrated Health*		
☐ **Contractor**		☐ **Subcontractor**	
Name:	*Anthony Q. Baxter*	☐ **Key Personnel**	
Classification:	*CEO*	**# of Years in Classification:**	*6 yrs*
Brief Summary: of Experience:	*University faculty member (Computer Science); industry & government consulting (IT related); CorrectCare management; military veteran*		
# of Years with Firm:	*10 yrs (co-founder)*		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*4/2009 to Present* *Karen Creighton, Associate Director* *8260 Longleaf Drive* *Elk Grove, CA 95758* *916-691-5749* *Karen.Creighton@cdcr.ca.gov* *California Contract: CPHCS Agreement ICHC.08774—TPA Medical Claims Processing Services Agreement* *Provide claims adjudication and related IT services for all CA prisons. My role is administrative oversight primarily as related to IT.*
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*8/2013 to Present* *Louisiana Department of Public Safety & Corrections* *CorrectCare – Integrated Health* *Melissa Steib, Chief Fiscal Officer* *504 Mayflower, P.O. Box 94304* *Baton Rouge, LA 70804-9304* *225-342-6553* *melissasteib@corrections.state.la.us* *Louisiana Contract: SFO No. 400PUR087/278—Third Party Administrator for Offender Health Claims* *Provide claims adjudication and related IT services for all LA prisons and Parrish jails. My role is administrative oversight primarily as related to IT.*

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***11/2003 to Present*** ***CorrectCare – Integrated Health*** ***Kentucky Department of Corrections*** ***Cookie Crews, KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***502-526-7259*** ***cookie.crews@ky.gov*** ***Kentucky Contract: PON2 527 1300001272 1—DOC Inmate Medical and Dental Services***

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***Union College; Schenectady NY – BS in Electrical Engineering*** ***Union College; Schenectady NY – MS in Electrical Engineering*** ***University of Virginia, Charlottesville, VA. – PhD in Computer Science***

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Mirek Truszczynski, Professor*** ***Univ of Kentucky Computer Science*** ***Tel: 859 257-1971*** ***Fax: 859 323-1971*** ***mirek@cs.uky.edu*** ***Phil Roeder, PhD*** ***Director of KCHSN (the Univ. Ky / KYDOC Partnership), retired*** ***Tel: 859 233-4260*** ***Fax: none*** ***roeder@email.uky.edu*** ***Karen Creighton, Associate Director*** ***8260 Longleaf Drive*** ***Elk Grove, CA 95758*** ***Tel: 916-691-5749*** ***Karen.Creighton@cdcr.ca.gov***

COMPANY NAME:	*CorrectCare – Integrated Health*		
☐ **Contractor**		☐ **Subcontractor**	
Name:	*Linda L. Goins*	☐ **Key Personnel**	
Classification:	*President*	**# of Years in Classification:** *3*	
Brief Summary: of Experience:	*Linda joined CorrectCare – Integrated Health in 2003 as the Project Coordinator for the partnership between the University of Kentucky and the Kentucky Department of Corrections. She later became Vice-President, and was named President of the organization in 2010. Linda developed and implemented CCIH's correctional Utilization Management Program. She also provides oversight of Claims Administration and Provider Network functions. Linda was instrumental in securing CCIH's claims administration contracts with the California Prison Heath Care Services and the Louisiana Department of Public Safety and Corrections.. She works actively with all business development activities and oversees the preparation of business proposals.* *Prior to joining CorrectCare – Integrated Health, Linda spent 10 years in leadership roles within the Home Health Industry*		
# of Years with Firm:	10		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*042009 to Present* *CorrectCare – Integrated Health* *California Correctional Health Care Services (CCHCS)* *Karen Creighton, Associate Director* *8260 Longleaf Drive* *Elk Grove, CA 95758* *916-691-5749* *Karen.Creighton@cdcr.ca.gov* *CPHCS Agreement Number ICHC.08774—TPA Medical Claims Processing Services Agreement.* *Linda has provided Executive Oversight and Client Service functions since the contract initiation in 2009.*

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***082013 to Present*** ***CorrectCare – Integrated Health*** ***Louisiana Department of Public Safety & Corrections*** ***Melissa Steib, Chief Fiscal Officer*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***225-342-6553*** ***melissasteib@corrections.state.la.us*** ***SFO No. 400PUR087/278—Third Party Administrator for Offender Health Claims*** ***Linda provide Executive Oversight to the contract.***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***11/2003 to Present*** ***CorrectCare – Integrated Health*** ***Kentucky Department of Corrections*** ***Cookie Crews, KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***502-526-7259*** ***cookie.crews@ky.gov*** ***PON2 527 1300001272 1—DOC Inmate Medical and Dental Services*** ***Linda developed the Correctional UM Program for this contract and provides oversight for the UM Program. She provides executive oversight to all other services, including claims administration, staffing, and contract management.***

EDUCATION	
Institution Name:	***Midway College***
City:	***Midway***
State:	***Kentucky***
Degree/Achievement:	***ADN, Organizational Management***
Certifications:	***RN***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Karen Creighton*** ***Associate Director*** ***CCHCS*** ***8260 Longleaf Drive*** ***Elk Grove, CA 95758*** ***Karen.Creighton@cdcr.ca.gov*** ***916-691-5749*** ***916-691-3940 (fax)*** ***Melissa Steib*** ***Chief Fiscal Officer*** ***Louisiana Department of Public Safety & Corrections*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***melissasteib@corrections.state.la.us*** ***225-342-6553*** ***225-219-9354 (fax)*** ***Cookie Crews*** ***KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***cookie.crews@ky.gov*** ***502-526-7259*** ***502-222-7895 (fax)***

COMPANY NAME:	*CorrectCare-Integrated Health, Inc.*		
☐ **Contractor**		☐ **Subcontractor**	
Name:	*James Edwin Burkhardt*	☐ **Key Personnel**	
Classification:	*Chief Operating Officer*	**# of Years in Classification:**	*Almost 6*
Brief Summary: of Experience:	*Jim has almost 30 years experience in Finance, Accounting, Budget and Strategic Plan. He joined CorrectCare - Integrated Health as Chief Operating Officer in March 2007 after an 18 year career with Ashland, Inc.* *As Chief Operating Officer he has responsibility for the company's accounting and administrative functions including human resources. He also manages banking, audit and tax, insurance and legal counsel relationships and all contracts.* *Jim supervises the claims payment and reconciliation process with the Kentucky Department of Corrections and the Louisiana Department of Corrections and invoicing for all claims processing services.*		
# of Years with Firm:	*Almost 6*		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*April 2009 to Present* *CorrectCare Integrated Health, Inc.* *California Correctional Health Care Services* *Mr. David Hale* *8260 Longleaf Drive, Elk Grove, CA; (916) 691-2597; David.Hale@cdcr.gov* *Office administration & support, invoicing & accounting* *Adjudication of inmate medical claims for all CDCR adult and juvenile institutions. With extension to June 2015, contract duration is 6 years.*
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*June 2013 to March (possible June) 2014* *CorrectCare Integrated Health, Inc.* *Louisiana Department of Public Safety & Corrections* *Ms. Melissa Steib* *504 Mayflower, P.O. Box 94304, Baton Rouge, LA; (225) 342-6553; msteib@corrections.state.la.us* *Office administration & support, invoicing, claims account bank reconciliation & accounting* *Claims adjudication and payment for offenders.* *Project duration is 9 months, possibly 12.*

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***March 2007 (when I joined the company) to Present*** ***CorrectCare Integrated Health, Inc.*** ***Kentucky Department of Corrections*** ***Ms. Cookie Crews*** ***2605 West Hwy 146, LaGrange, KY; (502) 526-7259; cookie.crews@ky.gov*** ***Office administration & support, human resources, contract management, invoicing, claims account bank reconciliation & accounting*** ***Claims administration, UM, PPO network access, medical staffing, medical contract management and E.H.R. system. This project started in October 2003 and continues to this day (10+ years).***

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***West Virginia University and the University of Virginia*** ***Morgantown and Charlottesville*** ***West Virginia and Virginia*** ***B.S. Industrial Engineering (cum laude) and Master of Business Administration***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Ms. Karen Creighton*** ***Associate Director, Healthcare Invoicing, Data and Provider Services Branch*** ***California Correctional Health Care Services*** ***P: (916) 691-5749; F: (916) 691-3940*** ***Karen.Creighton@cdcr.ca.gov*** ***Ms. Stacey Brown*** ***Director of Accounts Payable and Special Project Accounting*** ***Louisiana Department of Corrections*** ***P: (225) 342-6543; F: (225) 219-9354*** ***staceybrown@corrections.state.la.us*** ***Ms. Janice Stanley*** ***Fiscal Manager*** ***Kentucky Department of Corrections – Health Service Division*** ***P: (502) 222-7808; F: (502) 222-7895*** ***JaniceM.Stanley@ky.gov***

COMPANY NAME:	*CorrectCare – Integrated Health*		
☐ ☐☐☐**Contractor**		☐ ☐☐☐**Subcontractor**	
Name:	*Arthur Leroy Hall III*	☐ **Key Personnel**	
Classification:	*Chief Information Officer*	**# of Years in Classification:**	*1*
Brief Summary: of Experience:	*Art Hall has eighteen years of experience in Information Technology, with ten of those years being in a management position. He holds both a Bachelors and Master's degree in Computer Science. From June of 2004 to December 2012 he served as CCIH's Director of Technology. In December 2012 he was promoted to Chief Information Officer.* *Art supervises all software development and is responsible for the IT infrastructure. His extensive experience with information exchange has been leveraged to build the numerous data interfaces with CCIH business partners: providers and provider networks, clients, clearinghouses, and state agencies. He is responsible for the communications infrastructure for the organization, development of automation tools, and data mining and reporting tools.*		
# of Years with Firm:	*9.5*		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*042009 to Present* *CorrectCare – Integrated Health* *California Correctional Health Care Services (CCHCS)* *Karen Creighton, Associate Director* *8260 Longleaf Drive* *Elk Grove, CA 95758* *916-691-5749* *Karen.Creighton@cdcr.ca.gov* *CPHCS Agreement Number ICHC.08774—TPA Medical Claims Processing Services Agreement Oversaw development of several interfaces with different government agencies for exchanging data. These include the payment interface with California Department of Corrections and Rehabilitation (CDCR), the audit interface with the State Controller's Office (SCO) and the Medi-Cal interface with the Department of Health Care Services (DHCS). Continuing support and maintenance of data and interfaces.*

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***082013 to Present*** ***CorrectCare – Integrated Health*** ***Louisiana Department of Public Safety & Corrections*** ***Melissa Steib, Chief Fiscal Officer*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***225-342-6553*** ***melissasteib@corrections.state.la.us*** ***SFO No. 400PUR087/278—Third Party Administrator for Offender Health Claims*** ***EDI interfaces to various companies and providers in support of claims adjudication and payment.***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***11/2003 to Present*** ***CorrectCare – Integrated Health*** ***Kentucky Department of Corrections*** ***Cookie Crews, KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***502-526-7259*** ***cookie.crews@ky.gov*** ***EDI interfaces to various companies and providers in support of claims adjudication and payment.***

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***University of Kentucky*** ***Lexington*** ***KY*** ***Masters of Science, Computer Science*** ***University of Maine*** ***Orono*** ***Maine*** ***Bachelors of Science, Computer Science***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Karen Creighton*** ***Associate Director*** ***CCHCS*** ***8260 Longleaf Drive*** ***Elk Grove, CA 95758*** ***Karen.Creighton@cdcr.ca.gov*** ***916-691-5749*** ***916-691-3940 (fax)*** ***Melissa Steib*** ***Chief Fiscal Officer*** ***Louisiana Department of Public Safety & Corrections*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***melissasteib@corrections.state.la.us*** ***225-342-6553*** ***225-219-9354 (fax)*** ***Cookie Crews*** ***KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***cookie.crews@ky.gov*** ***502-526-7259*** ***502-222-7895 (fax)***

COMPANY NAME:	*CorrectCare – Integrated Health*		
☐ **Contractor**		☐ **Subcontractor**	
Name:	*Brian Cundiff*	☐ **Key Personnel**	
Classification:	*Director Claims Services*	**# of Years in Classification:**	*25*
Brief Summary: of Experience:	*Brian Cundiff has 25 years of experience in the Claim industry with 15 of those years being in a management position. Prior to joining CCIH Brian worked for Acordia, Anthem BC/BS and others. His supervisory experience includes the management of claims staff, client support teams, training, auditing, provider database management, claims adjustments and quality assurance.* *Brian joined CorrectCare – Integrated Health in 2006. As Director of Claim Services, Brian is responsible for both claims administration and provider network functions. During his tenure with CorrectCare, Brian implemented the transition from claims subcontracting to an in-house claims processing system. Brian has been instrumental in CCIH's successful expansion of TPA services including the California Correctional Health Care Services and the Louisiana DPS&C contract.*		
# of Years with Firm:	*7.5*		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*042009 to Present* *CorrectCare – Integrated Health* *California Correctional Health Care Services (CCHCS)* *Karen Creighton, Associate Director* *8260 Longleaf Drive* *Elk Grove, CA 95758* *916-691-5749* *Karen.Creighton@cdcr.ca.gov* *CPHCS Agreement Number ICHC.08774—TPA Medical Claims Processing Services Agreement*

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***082013 to Present*** ***CorrectCare – Integrated Health*** ***Louisiana Department of Public Safety & Corrections*** ***Melissa Steib, Chief Fiscal Officer*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***225-342-6553*** ***melissasteib@corrections.state.la.us*** ***SFO No. 400PUR087/278—Third Party Administrator for Offender Health Claims***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***11/2003 to Present*** ***CorrectCare – Integrated Health*** ***Kentucky Department of Corrections*** ***Cookie Crews, KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***502-526-7259*** ***cookie.crews@ky.gov*** ***PON2 527 1300001272 1—DOC Inmate Medical and Dental Services***

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***Eastern Kentucky University*** ***Richmond*** ***KY*** ***General Education Requirements***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Karen Creighton*** ***Associate Director*** ***CCHCS*** ***8260 Longleaf Drive*** ***Elk Grove, CA 95758*** ***Karen.Creighton@cdcr.ca.gov*** ***916-691-5749*** ***916-691-3940 (fax)*** ***Melissa Steib*** ***Chief Fiscal Officer*** ***Louisiana Department of Public Safety & Corrections*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***melissasteib@corrections.state.la.us*** ***225-342-6553*** ***225-219-9354 (fax)*** ***Cookie Crews*** ***KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***cookie.crews@ky.gov*** ***502-526-7259*** ***502-222-7895 (fax)***

COMPANY NAME:	*CorrectCare - Integrated Health*		
☐ **Contractor**		☐ **Subcontractor**	
Name:	*Trisha Maddox Back*		☐ **Key Personnel**
Classification:	*Claim Manager*	**# of Years in Classification:**	11
Brief Summary: of Experience:	• *Over 30 years claim processing experience in Medical, Dental, Disability and FSA claim administration and processing.* • *11 years experience in Claim Management including the management of staff from 5-20, client support, training, and auditing.* • *10 years experience in a Customer Service/Call Center environment.* • *Experience in a system conversion from DOS system to windows version.*		
# of Years with Firm:	*5*		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*052009-Present* *CorrectCare- Integrated Health* *California Correctional Health Care Services (CCHCS)* *Karen Creighton, Associate Director* *8260 Longleaf Drive* *Elk Grove, CA 95758* *916-691-5749* *Karen.Creighton@cdcr.ca.gov* *CPHCS Agreement Number ICHC.08774-TPA* *Medical Claims Processing Service Agreement*
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*022002 to 052009* *Health Service Review (HSR Administrators)* *Magellan Aerospace* *John Furbay - Steve Puckett* *2320 Wedekind Drive* *Middletown, Ohio 45042* *513-422-2751* *TPA - UR, Case management and Medical Claims Processing*
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*042003 to 052009* *Health Service Review (HRS Administrators)* *Principal at Plancorp Inc* *Rebeccah E Randles* *9050 Sweet Valley Drive* *Valley View, OH 44125* *216-642-1099* *Administration and management of UR, Case management, Stop Loss and Health Insurance claims.*

EDUCATION	
Institution Name:	***Southern Ohio College***
City:	***Hamilton***
State:	***Ohio***
Degree/Achievement:	***Computer Programming and Data Entry***
Certifications:	

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Karen Creighton*** ***Associate Director*** ***CCHCS*** ***8260 Longleaf Drive*** ***Elk Grove, CA 95758*** ***916-691-5749*** ***916-691-3940 (fax)*** ***Karen.Creighton@cdcr.ca.gov*** ***Debra Hall*** ***Director Claims Service*** ***Custom Design Benefits*** ***5589 Cheviot Road*** ***Cincinnati, OH 45247*** ***513-598-7786*** ***dhall@customdesignbenefits.com*** ***Don Barker*** ***President*** ***Health Service Review (HSR Administrators)*** ***6730 Roosevelt*** ***Franklin, OH 45005*** ***800-573-0009*** ***513-309-4595*** ***dbarker@healthservicereview.com***

COMPANY NAME:	*CorrectCare – Integrated Health*		
☐ **Contractor**		☐ **Subcontractor**	
Name:	*Jane Xu*	☐ **Key Personnel**	
Classification:	*Senior Developer*	**# of Years in Classification:**	*12*
Brief Summary: of Experience:	*Jane Xu has twelve years of experience in database and software development and is responsible for customizing the system at CorrectCare-Integrated Health. Her extensive experience with information exchange has been leveraged to build the numerous data interfaces with CCIH business partners: providers, provider networks, clients and clearinghouses. Jane has extensive experience working with ANSI X12-4010 and ANSI X12-5010.*		
# of Years with Firm:	*4.5*		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*042009 to Present* *CorrectCare – Integrated Health* *California Correctional Health Care Services (CCHCS)* *Karen Creighton, Associate Director* *8260 Longleaf Drive* *Elk Grove, CA 95758* *916-691-5749* *Karen.Creighton@cdcr.ca.gov* *CPHCS Agreement Number ICHC.08774—TPA Medical Claims Processing Services Agreement* *Built automated information exchanges for all areas of medical claim processing from eligibility to provider payment.*
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*082013 to Present* *CorrectCare – Integrated Health* *Louisiana Department of Public Safety & Corrections* *Melissa Steib, Chief Fiscal Officer* *504 Mayflower, P.O. Box 94304* *Baton Rouge, LA 70804-9304* *225-342-6553* *melissasteib@corrections.state.la.us* *SFO No. 400PUR087/278—Third Party Administrator for Offender Health Claims* *Built automated information exchanges for all areas of medical claim processing from eligibility to provider payment.*

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***11/2003 to Present*** ***CorrectCare – Integrated Health*** ***Kentucky Department of Corrections*** ***Cookie Crews, KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***502-526-7259*** ***cookie.crews@ky.gov*** ***PON2 527 1300001272 1—DOC Inmate Medical and Dental Services*** ***ANSI X-12 EDI with provider network and clearinghouses.***

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***Texas A&M university*** ***College Station*** ***TX*** ***Master of Computer Science*** ***Basic HIPAA Privacy & Security***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Karen Creighton*** ***Associate Director*** ***CCHCS*** ***8260 Longleaf Drive*** ***Elk Grove, CA 95758*** ***Karen.Creighton@cdcr.ca.gov*** ***916-691-5749*** ***916-691-3940 (fax)*** ***Melissa Steib*** ***Chief Fiscal Officer*** ***Louisiana Department of Public Safety & Corrections*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***melissasteib@corrections.state.la.us*** ***225-342-6553*** ***225-219-9354 (fax)*** ***Cookie Crews*** ***KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***cookie.crews@ky.gov*** ***502-526-7259*** ***502-222-7895 (fax)***

COMPANY NAME:	*CorrectCare – Integrated Health*		
☐ **Contractor**		☐ **Subcontractor**	
Name:	*Raymond Richardson*	☐ **Key Personnel**	
Classification:	*Software Developer*	**# of Years in Classification:**	*4*
Brief Summary: of Experience:	*Over 13 years of experience covering all phases of software development life-cycle including 2 years of project management, 2 years as supervisor, and 4 years of change management.*		
# of Years with Firm:	*4*		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*042009 to Present* *CorrectCare – Integrated Health* *California Correctional Health Care Services (CCHCS)* *Karen Creighton, Associate Director* *8260 Longleaf Drive* *Elk Grove, CA 95758* *916-691-5749* *Karen.Creighton@cdcr.ca.gov* *Lead role in reporting, change management, technical documentation, and general system support for the claims production environment.* *CPHCS Agreement Number ICHC.08774—TPA Medical Claims Processing Services Agreement*
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	*082013 to Present* *CorrectCare – Integrated Health* *Louisiana Department of Public Safety & Corrections* *Melissa Steib, Chief Fiscal Officer* *504 Mayflower, P.O. Box 94304* *Baton Rouge, LA 70804-9304* *225-342-6553* *melissasteib@corrections.state.la.us* *Lead role in reporting, change management, and general system support for the claims production environment.* *SFO No. 400PUR087/278—Third Party Administrator for Offender Health Claims*

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***112003 to Present*** ***CorrectCare – Integrated Health*** ***Kentucky Department of Corrections*** ***Cookie Crews, KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***502-526-7259*** ***cookie.crews@ky.gov*** ***Provide general system support for the claims production environment.*** ***PON2 527 1300001272 1—DOC Inmate Medical and Dental Services***

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***University of Kentucky*** ***Lexington*** ***Kentucky*** ***Graduate Studies, Physics*** ***Eastern Kentucky University*** ***Richmond*** ***Kentucky*** ***B.S., Physics***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Karen Creighton*** ***Associate Director*** ***CCHCS*** ***8260 Longleaf Drive*** ***Elk Grove, CA 95758*** ***Karen.Creighton@cdcr.ca.gov*** ***916-691-5749*** ***916-691-3940 (fax)*** ***Melissa Steib*** ***Chief Fiscal Officer*** ***Louisiana Department of Public Safety & Corrections*** ***504 Mayflower, P.O. Box 94304*** ***Baton Rouge, LA 70804-9304*** ***melissasteib@corrections.state.la.us*** ***225-342-6553*** ***225-219-9354 (fax)*** ***Cookie Crews*** ***KYDOC Health Service Administrator*** ***2605 West Highway 146*** ***LaGrange, KY 400311-9742*** ***cookie.crews@ky.gov*** ***502-526-7259*** ***502-222-7895 (fax)***

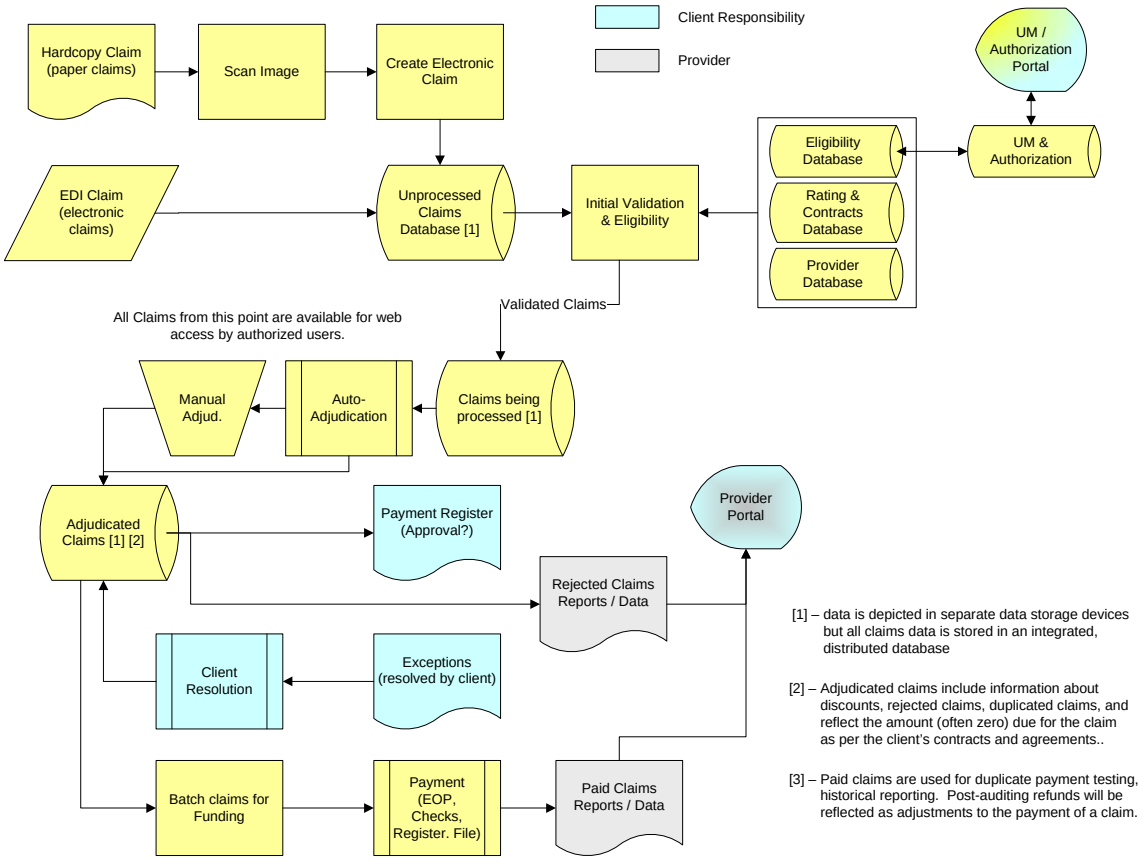
OTHER INFORMATIONAL MATERIAL

AUDIT STATISTICS

Below are audit statistics for random audits undertaken during the first part of of the curent year. They are typical of the peerformance during prior years.

AUDIT INFORMATION	Jan-13	Feb-13	Mar-13	April-13	May-13	June-13	July-13	Overall
NUMBER CLAIM AUDITED	2378	2043	2060	2241	1795	2619	2196	**15332**
DOLLAR OF CLAIM PAYMENTS AUDITED	$765,735.88	$607,492.19	$458,309.54	$634,456.88	$528,502.90	$713,838.39	$715,930.67	**$4,424,266.45**
OVERPAYMENTS	$564.28	$145.67	$1,984.01	$829.95	$138.78	$435.46	$759.80	**$4,857.95**
UNDERPAYMENTS	$283.40	$219.48	$310.45	$42.79	$121.09	$123.07	$541.64	**$1,641.92**
PROCEDURE ERRORS	4	7	22	11	0	4	3	**51**
NUMBER CLAIMS WITH ERRORS	11	19	47	25	4	16	21	**143**
FINANCIAL ACCURACY	99.89%	99.94%	99.50%	99.86%	99.95%	99.92%	99.82%	**99.85%**
CLAIM PAYMENT ACCURACY	99.54%	99.07%	97.72%	98.88%	99.78%	99.39%	99.04%	99.07%
RANDOM PERCENTAGE	3%	3%	3%	3%	3%	3%	3%	

FLOW DIAGRAM OF CLAIMS PROCESS



SAMPLE REPORTS

Below, and on the next few pages, are some sample reports we currently produce for clients. Sensitive information has been excluded from these samples.

During the initial implementation period, prior to the commencement of claims processing, we would work with you to create all reports that you needed; defining the data elements needed and the delivery method which best serves your needs.

Payment Range Summary

This report summarized payments, for a specified date range, for each correctional institution, or cost center.

007A - Payment Range Summary

Claims Processed: 1/1/2013 to 3/31/2013

NV Correctional Institution 1

	$0-2,500	$2,501-5,000	$5,000-10,000	$10,001-20,000	$20,001-50,000	> $50,000	Total Paid
Payments	$ 971,364.77	$ 162,467.45	$ 426,497.38	$ 462,842.98	$ 378,591.37	$ 452,439.25	$ 2,854,203.20
% Payments	34.03 %	5.69 %	14.94 %	16.22 %	13.26 %	15.85 %	
Claims	7592	49	61	33	12	5	7752
% Claims	97.94 %	0.63 %	0.79 %	0.43 %	0.15 %	0.06 %	

NV Correctional Institution 2

	$0-2,500	$2,501-5,000	$5,000-10,000	$10,001-20,000	$20,001-50,000	> $50,000	Total Paid
Payments	$ 520,891.28	$ 81,137.19	$ 211,121.43	$ 124,093.52	$ 87,473.99	$ 262,302.84	$ 1,287,020.25
% Payments	40.47 %	6.30 %	16.40 %	9.64 %	6.80 %	20.38 %	
Claims	4883	24	28	9	3	2	4949
% Claims	98.67 %	0.48 %	0.57 %	0.18 %	0.06 %	0.04 %	

NV Correctional Institution 3

	$0-2,500	$2,501-5,000	$5,000-10,000	$10,001-20,000	$20,001-50,000	> $50,000	Total Paid
Payments	$ 680,070.59	$ 117,954.96	$ 387,380.21	$ 320,342.98	$ 249,075.19	$ 77,885.25	$ 1,832,709.18
% Payments	37.11 %	6.44 %	21.14 %	17.48 %	13.59 %	4.25 %	
Claims	4190	34	55	23	9	1	4312
% Claims	97.17 %	0.79 %	1.28 %	0.53 %	0.21 %	0.02 %	

Claims Turnaround Summary

This report summarized the claims processing times (receipt to payment, or denial) of claims for one of our clients last month. The three locations with a large percentage of claims greater than 31 days were locations which the institutions had to process for payment locally and for which delays were out of our control

001B - Claims Turnaround Summary by Location

To accounting: 3/1/2013 to 3/31/2013

Institution	Total Claims	1-7 Days	8-14 Days	15-21 Days	22-28 Days	28+ Days	Avg. Days
Avenal State Prison	2656	207	2113	330	3	3	10.8
California Correctional Center	1427	157	1157	112	0	1	10.3
California Correctional Institution	1913	230	1499	178	3	3	10.5
California Institution for Men	3770	419	2860	472	7	12	10.6
California Institution for Women	1463	165	1173	122	1	2	10.2
California Medical Facility	3062	214	2326	492	29	1	11.5
California Men's Colony	3233	397	2404	413	14	5	10.5
California Rehabilitation Center	1591	185	1219	185	2	0	10.4
California State Prison, Corcoran	1458	105	1059	288	5	1	11.5
California State Prison, Los Angeles County	2205	199	1691	295	17	3	10.7
California State Prison, Sacramento County	1565	113	1272	175	5	0	11.0
California State Prison, San Quentin	3026	285	2356	375	9	1	10.8
California StatePrison, Solano County	3341	272	2447	613	4	5	11.2
California Substance Abuse Treatment Facility	2548	216	1785	536	8	3	11.5
Calipatria State Prison	1127	96	894	132	3	2	10.7
Centinela State Prison	964	95	704	159	5	1	11.2
Central California Women's Facility	2197	212	1758	221	4	2	10.5
Chuckawalla Valley State Prison	983	79	739	164	1	0	11.0
Correctional Training Facility	2336	253	1806	268	7	2	10.8
Deuel Vocational Institution	1242	157	938	147	0	0	10.5
Folsom State Prison	918	87	738	90	2	1	10.5
Head Quarters	134	5	85	43	1	0	13.4
High Desert State Prison	898	90	696	112	0	0	10.9
Ironwood State Prison	1373	135	1068	166	2	2	10.8
Kern Valley State Prison	1362	185	1017	155	2	3	10.6
Mule Creek State Prison	1896	107	1446	329	14	0	11.5
N. A. Chaderjian Youth Correctional Facility	91	0	20	59	10	2	39.2
North Kern State Prison	3365	621	2535	204	3	2	10.2
O.H. Close Youth Correctional Facility	42	0	3	32	7	0	40.4
Pelican Bay State Prison	820	66	696	56	0	2	10.3
Pine Grove Youth Conservation Camp	5	0	3	1	1	0	40.8
Pleasant Valley State Prison	1408	138	1137	131	1	1	10.5
R. J. Donovan Correctional Facility	2770	191	2120	437	13	9	11.5
Salinas Valley State Prison	1779	202	1298	265	11	3	10.8
Sierra Conservation Center	1194	160	891	141	2	0	10.5
Valley State Prison for Women	1202	138	974	88	1	1	10.3
Ventura Youth Correctional Facility	40	0	7	27	6	0	38.5
Wasco State Prison	4303	573	3329	389	7	5	10.3
	65,707	**6,754**	**50,263**	**8,402**	**210**	**78**	**10.8**

No Pay Claims Detail

This report lists all claims, for one or more, providers in a specified date range which were denied by CCIH. The provider is given this information with a denial and the details can be obtained when needed. This shows the denial reason for each line on the claim.

008E-1 - No Pay Claims Detail

Claims Finalized: 1/1/2013 - 2/28/2013

Sample Provider Name

ID	Invoice	Claim Number	Dates of Service	Received	Finalized	Lock
	Code	No Pay Reason				Billed
xxxxxxx	641424	2013-022000005-0000e	01/02/2013-01/02/2013	01/16/2013	01/29/2013	7530
	521	Non Covered (CCIH): [6] Inmate Not Eligible				$ 154.00
						$ 154.00
xxxxxxx	642657	2013-023000228-0000e	01/02/2013-01/03/2013	01/17/2013	01/30/2013	7532
	250	Non Covered (CCIH): [288] Services packaged into APC rate				$ 227.00
	250	Non Covered (CCIH): [193,194] Code is component of another , therefore not				$ 136.00
	250	Non Covered (CCIH): [295,296] Incidental services packaged , into APC rate.				$ 8.50
	258	Non Covered (CCIH): [295,296] Incidental services packaged , into APC rate.				$ 73.50
	271	Non Covered (CCIH): [295,296] Incidental services packaged , into APC rate.				$ 25.50
	272	Non Covered (CCIH): [295,296] Incidental services packaged , into APC rate.				$ 146.50
	350	Non Covered (CCIH): [288] Services packaged into APC rate				$ 1,814.50
	450	Non Covered (CCIH): [288] Services packaged into APC rate				$ 1,323.00
	960	Non Covered (CCIH): [195,196] Code not recognized by OPPS, alternate code				$ 25.50
						$ 3,780.00
xxxxxxx	643937	2013-046000675-0000	01/03/2013-01/03/2013	02/05/2013	02/21/2013	7617
	250	Duplicate: [24] Duplicate Charge				$ 17.00
	250	Duplicate: [24] Duplicate Charge				$ 17.00
	250	Duplicate: [4] Expense Not Covered by Plan				$ 138.45
	272	Duplicate: [24] Duplicate Charge				$ 11.50
	301	Duplicate: [24] Duplicate Charge				$ 145.00
	305	Duplicate: [24] Duplicate Charge				$ 83.00
	320	Duplicate: [24] Duplicate Charge				$ 172.50
	324	Duplicate: [24] Duplicate Charge				$ 154.50
	350	Duplicate: [24] Duplicate Charge				$ 1,275.50
	350	Duplicate: [24] Duplicate Charge				$ 1,814.50
	450	Duplicate: [24] Duplicate Charge				$ 1,323.00
	460	Duplicate: [24] Duplicate Charge				$ 94.50
						$ 5,246.45

Top Procedures

This report, with claims selected by date of service, summarizes the number and amount of claims grouped by CPT code. This example is sorted by total expense with only the top 25 being displayed.

Top 25 High-Cost Procedures

by claim line with line-item procedure code

Date of service: 1/1/2013 to 2/28/2013

	Code	Procedure Description	Procs	Billed	Paid	Average	Std. Dev.
1	90999	Dialysis procedure NEC	361	9,820,360.00	650,602.60	1,802.22	15,540.89
2	A0425	GROUND MILEAGE PER STATUTE MILE	1,680	1,206,235.99	540,978.48	322.01	971.08
3	A0427	AMB SERVICE ALS EMERGENCY TRANSPORT LEVEL 1	971	1,026,525.16	529,281.73	545.09	549.05
4	87902	Infct antigen genotype analy, Hep C	1,376	847,151.34	376,680.65	273.75	107.75
5	99285	Emergency dept visit, high	1,438	1,679,461.83	338,390.31	235.32	1,324.93
6	99232	Followup hospital care, moderate	3,308	415,115.28	253,205.29	76.54	67.02
7	99223	Initial hospital care, high	1,121	364,364.94	241,443.70	215.38	148.17
8	99214	Office/outpatient visit, est, mod	1,900	343,643.51	225,009.33	118.43	65.43
9	99233	Followup hospital care, extensive	1,963	367,356.98	217,161.54	110.63	95.57
10	80061	Lipid profile	14,900	1,738,794.46	213,991.65	14.36	26.55
11	77418	Radtn Tx delv, intensity modulated	407	1,189,856.88	211,475.63	519.60	2,892.98
12	99213	Office/outpatient visit, est, mod	2,479	292,917.05	193,896.10	78.22	57.62
13	87591	Infct antign, neisseria gon, ampl	5,169	512,049.95	193,190.52	37.37	7.59
14	87491	Infct antign, chlamydia trac, ampl	5,166	511,736.57	193,080.20	37.38	7.57
15	80053	Metabolic panel, comprehensive	13,766	1,165,575.73	185,301.82	13.46	90.95
16	99284	Emergency dept visit, high	908	973,242.45	183,865.51	202.50	852.90
17	99204	Office/outpatient visit, new, mod	1,030	275,733.78	179,630.83	174.40	94.84
18	99205	Office/outpatient visit, new, high	733	237,180.44	161,720.85	220.63	95.48
19	87522	Infct antign, hepatitis C, quan	3,422	1,770,310.22	155,852.73	45.54	13.75
20	99215	Office/outpatient visit, est, high	931	232,827.29	149,299.48	160.36	112.93
21	70450	CAT scan of head/brain	701	859,005.95	142,342.72	203.06	1,654.22
22	43239	Upper GI endoscopy, w/biopsy	389	620,833.75	140,437.01	361.02	1,770.41
23	99291	Critical care, first hour	519	372,678.35	139,194.86	268.20	903.57
24	47000	Needle biopsy of liver	344	399,712.33	135,444.78	393.73	1,167.44
25	49505	Repair ingnl hernia, 5+ yrs, reduc	100	447,217.58	133,791.62	1,337.92	4,209.56

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Vendor Claim Detail

This report selects one, or more claims, and displays the details of payment. It, or some similar variant, are used to provide payment information to the client or can be further summarized to act as a payment register

Nevada Department of Corrections

016B - Vendor Claim Details

Sample Hospital [99-9999999]
Provider: Sample Provider
CCIH Claim Number: 2013-072002397-0000

DOC ID	Name	SID	Location	Date Rec'd	Vendor Claim No.	Dates of Service	Check No.	Date Paid	Place of Service
12345678	Inmate Name	98765432	Jail or Prison	03/06/2013	3584Z12231	12/01/2012-12/01/2012	68421746	03/29/2013	21

Diagnosis: 552.21 OBSTR INCISIONAL HERNIA

Procedure(s)	Adjudication Notes	Coverage Code	Billed	Paid
[99223-57] Initial hospital care, high	Contracted Rates Applied	Inpatient Phys Visit	$ 419.52	$ 198.66
[49000] Exploration of abdomen	Component included with other CPT billed for date of service.	Not covered	$ 1,623.07	$ 0.00
[49020-59] Drainage of peritoneal abscess, opn	Included in Global Surgical package for another CPT.	Not covered	$ 3,330.57	$ 0.00
[11044-59] Surg cleansing, tissue/muscle/bone	Included in Global Surgical package for another CPT.	Not covered	$ 705.11	$ 0.00
[15777-59] Impl. of bio implant for soft tissue reinforce	Contracted Rates Applied	Inpatient Surgery	$ 449.90	$ 210.62
[49568-59] Rpr incision/ventral hernia w/mesh	CPT is add on code and cannot be CPT is add on code and cannot be	Not covered	$ 553.43	$ 0.00
			$ 7,081.60	$ 409.28

Provider Claim Summary

This report lists processed claims and summarized their disposition.

008H - Provider Claim Summary

Finalized: 1/1/2013 to 2/28/2013

Provider	Claims	Paid	DUPs	NCOV	Ref'd	Ad'tl. Pmts	Other	Total No Pay	Total Billed	Total Paid
UNILAB CORPORATION	82,582	74,897	510	1,248	5,927	0	0	1,758	21,573,582.08	2,280,956.87
TRUXTUN RADIOLOGY MED GROUP	6,727	6,247	60	419	0	1	0	479	232,408.54	121,003.75
PREMIER PHYSICIAN ALLIANCE INC	3,342	3,193	24	118	6	1	0	142	797,248.79	632,478.55
SAN JOAQUIN GENERAL HOSPITAL	2,572	2,206	139	224	0	3	0	363	16,241,553.38	5,234,110.65
ALVARADO HOSPITAL LLC	2,265	2,053	66	145	1	0	0	211	6,038,099.99	1,512,565.19
COLONIAL MEDICAL GROUP	2,001	1,930	14	53	1	3	0	67	2,815,254.08	696,252.51
SHARED IMAGING LLC	1,751	1,679	9	17	46	0	0	26	532,250.16	520,579.85
DESERT ADVANCED IMAGING MED CENTER	1,693	1,648	1	44	0	0	0	45	74,034.00	32,166.18
COUNTY OF RIVERSIDE REGIONAL	1,619	1,112	94	399	14	0	0	493	11,447,514.30	1,459,155.41
GOLDEN EMPIRE MANAGED CARE MED GRP	1,604	936	556	112	0	0	0	668	382,641.70	180,184.85
FACULTY PHYSICANS AND SURGEONS	1,160	630	447	83	0	0	0	530	880,738.75	117,076.65
CA EMERGENCY PHYS MED GROUP	991	927	5	59	0	0	0	64	570,145.00	173,755.93
COUNTY OF MONTEREY	903	702	51	150	0	0	0	201	11,850,619.24	1,884,094.91
PAIR AND MAROTTA PHYSICAL THERAPY I	873	829	17	27	0	0	0	44	144,649.00	80,500.63
VALLEY RADIOLOGY MEDICAL ASSOC	859	840	0	19	0	0	0	19	43,506.00	17,395.46
SAN JOAQUIN COMMUNITY HOSPITAL	832	779	19	34	0	0	0	53	12,770,605.30	3,432,897.63
REGENTS OF THE UNIV OF CA	688	599	22	65	0	2	0	87	326,613.00	65,114.15
RENAISSANCE RADIOLOGY MED GRP	647	586	26	33	2	0	0	59	62,298.50	18,382.38
MERCY HOSPITAL	635	567	44	16	7	1	0	60	10,565,615.61	2,271,231.26
TRI CITY MEDICAL CENTER	635	551	45	39	0	0	0	84	17,345,197.76	3,003,449.84
DIAGNOSTIC RADIOLOGICAL IMAGING	586	570	0	16	0	0	0	16	23,772.00	10,513.44

Payment Registers

There are several reports which serve as payment registers; one which lists one line per claim for which payment is recommended (this version included denied claims; other similar repots include only claims with payments) and a more detailed one listing the individual procedures billed. Below is the abbreviated register; report totals would be found at the bottom of the report.

Payment Register

Finalized Dates: 2.1.2013 - 2/15/2013

GALVESTON COUNTY JAIL

Vendor: BARRIER REEF EMERGENCY PHYS [270316031]

Offender #	Name	CCIH Claim No.	Received	Dates of Services	Claim Type	Date Finalized	Billed	Paid
XX01-31XX	LastName, MIKE	2013-014001372-0000	01/14/13	12/26/12-12/26/12	Approved Payment	02/15/13	$ 1,940.00	$ 1,940.00
Offender #	**Name**	**CCIH Claim No.**	**Received**	**Dates of Services**	**Claim Type**	**Date Finalized**	**Billed**	**Paid**
XX01-14XX	LastName, RONALD	2013-037001293-0000	02/06/13	11/14/12-11/14/12	No Payment	02/15/13	$ 1,323.00	$ 0.00
					Claims: **2**		**$ 3,263.00**	**$ 1,940.00**

Vendor: CLEAR LAKE REGIONAL MEDICAL CENTER [621801360]

Offender #	Name	CCIH Claim No.	Received	Dates of Services	Claim Type	Date Finalized	Billed	Paid
XX01-35XX	LastName, DANIELLE	2013-037001314-0000	02/06/13	11/03/12-11/03/12	Approved Payment	02/15/13	$ 1,032.00	$ 670.80
					Claims: **1**		**$ 1,032.00**	**$ 670.80**

Vendor: UTMB AT GALVESTON [746000949]

Offender #	Name	CCIH Claim No.	Received	Dates of Services	Claim Type	Date Finalized	Billed	Paid
XX01-14XX	LastName, ANDREW	2013-030003306-0000	01/30/13	12/28/12-12/28/12	Approved Payment	02/15/13	$ 6,855.00	$ 4,455.75
XX01-26XX	LastName, BRIAN	2013-030003296-0000	01/30/13	12/14/12-12/14/12	Approved Payment	02/15/13	$ 878.00	$ 570.70
XX01-26XX	LastName, BRIAN	2013-030003301-0000	01/30/13	11/29/12-11/29/12	Approved Payment	02/15/13	$ 285.00	$ 185.25
XX01-26XX	LastName, BRIAN	2013-030003303-0000	01/30/13	12/14/12-12/14/12	Approved Payment	02/15/13	$ 4,528.78	$ 2,943.71
XX01-25XX	LastName, CODYE	2013-030003307-0000	01/30/13	08/24/12-08/28/12	Approved Payment	02/15/13	$ 20,742.49	$ 14,999.89
XX01-35XX	LastName, EVAN	2013-030003297-0000	01/30/13	12/17/12-12/17/12	Approved Payment	02/15/13	$ 451.00	$ 293.15
XX01-35XX	LastName, FABIAN	2013-030003309-0000	01/30/13	12/08/12-01/11/13	No Payment	02/15/13	$ 144,675.70	$ 0.00
XX01-10XX	LastName, JOHN	2013-030003300-0000	01/30/13	12/20/12-12/20/12	Approved Payment	02/15/13	$ 216.00	$ 140.40
XX01-10XX	LastName, JOHN	2013-030003302-0000	01/30/13	11/29/12-11/29/12	Approved Payment	02/15/13	$ 216.00	$ 140.40
XX01-14XX	LastName, JOHNNY	2013-030003299-0000	01/30/13	12/09/12-12/10/12	Approved Payment	02/15/13	$ 12,165.90	$ 7,638.73
XX01-30XX	LastName, LEON	2013-030003289-0000	01/28/13	07/08/12-07/08/12	Approved Payment	02/15/13	$ 4,815.38	$ 3,130.00
XX01-23XX	LastName, MICHAEL	2013-030003308-0000	01/30/13	08/20/12-08/29/12	Approved Payment	02/15/13	$ 1,507.54	$ 979.90
XX01-31XX	LastName, MIKE	2013-030003298-0000	01/30/13	12/26/12-01/04/13	No Payment	02/15/13	$ 42,589.43	$ 0.00
XX01-28XX	LastName, REYNALDO	2013-030003294-0000	01/30/13	12/23/12-12/23/12	Approved Payment	02/15/13	$ 2,600.00	$ 1,690.00
XX01-28XX	LastName, REYNALDO	2013-030003304-0000	01/30/13	12/23/12-12/23/12	Approved Payment	02/15/13	$ 3,400.00	$ 2,210.00
XX01-22XX	LastName, RONALD	2013-030003295-0000	01/30/13	12/03/12-12/03/12	Approved Payment	02/15/13	$ 464.00	$ 301.60
XX01-24XX	LastName, STEPHEN	2013-030003305-0000	01/30/13	11/27/12-11/27/12	Approved Payment	02/15/13	$ 216.00	$ 140.40
					Claims: **17**		**$ 246,606.22**	**$ 39,819.88**

Below is an example of a more detailed payment register.

Detailed Payment Register

Finalized Dates: 2.1.2013 - 2/15/2013

GALVESTON COUNTY JAIL

Vendor: BARRIER REEF EMERGENCY PHYS [270316031]

Physician: GREGORY RUMPH [270316031]

Offender #	Name	CCIH Claim No.	Received	Dates of Services	Payment	Date Finalized	POS	PPO
XX01-31XX	Last_Name, MIKE	2013-014001372-0000	01/14/13	12/26/12-12/26/12	Check # here	02/15/13	23	Non-Participating

Procedure(s): [CPT and/or UB-92]	Adjudication Notes	Coverage Code	Billed	Paid
[99285-25] Emergency dept visit, high	Non par provider, no discount.	Emergency Room Visit	$ 1,323.00	$ 1,323.00
[62270] Diagnostic spinal fluid tap, lumbar	Non par provider, no discount.	Office Surgery	$ 617.00	$ 617.00
			$ 1,940.00	$ 1,940.00

Physician: JAMES HUNDERUP [270316031]

Offender #	Name	CCIH Claim No.	Received	Dates of Services	Payment	Date Finalized	POS	PPO
XX01-14XX	Last_Name, RONALD	2013-037001293-0000	02/06/13	11/14/12-11/14/12	No Payment	02/15/13	23	Non-Participating

Procedure(s): [CPT and/or UB-92]	Adjudication Notes	Coverage Code	Billed	Paid
[99285] Emergency dept visit, high	Jail not responsible for payment	Not Covered	$ 1,323.00	$ 0.00
			$ 1,323.00	$ 0.00

Physician Totals: JAMES HUNDERUP [270316031] **Claims: 1** **Billed: $ 1,323.00** **Paid: $ 0.00**

Vendor Totals: BARRIER REEF EMERGENCY PHYS [270316031] **Claims: 2** **Billed: $ 3,263.00** **Paid: $ 1,940.00**

Vendor: CLEAR LAKE REGIONAL MEDICAL CENTER [621801360]

Offender #	Name	CCIH Claim No.	Received	Dates of Services	Payment	Date Finalized	POS	PPO
XX01-35XX	Last_Name, DANIELLE	2013-037001314-0000	02/06/13	11/03/12-11/03/12	Check # here	02/15/13	22	PrimeHealth Services Inc.

Procedure(s): [CPT and/or UB-92]	Adjudication Notes	Coverage Code	Billed	Paid
[99282&450] Emergency dept visit, low-moderate & EMERGENCY ROOM	PPO Benefits applied.	Emergency Room Visit	$ 681.00	$ 442.65
[12001&450] Repair superficial wounds, trunk & EMERGENCY ROOM	PPO Benefits applied.	Emergency Room Visit	$ 351.00	$ 228.15
			$ 1,032.00	$ 670.80

Vendor Totals: CLEAR LAKE REGIONAL MEDICAL CENTER **Claims: 1** **Billed: $ 1,032.00** **Paid: $ 670.80**

Provider: UTMB AT GALVESTON [99-9999999]

Physician: UTMB AT GALVESTON [746000949]

Offender #	Name	CCIH Claim No.	Received	Dates of Service	Check	Date Finalized	POS	PPO
9999999	Inmate_Last_Name, ANDREW	2013-030003306-0000	01/30/13	12/28/12-12/28/12	To Be Paid	02/15/13	22	PrimeHealth Services Inc.

Procedure(s): [CPT &/or UB-92]	Adjudication Notes	Coverage Code	Billed	Paid
[80048&301] Metabolic panel, basic & LAB/CHEMISTRY	PPO Benefits applied.	Laboratory Test	$ 60.00	$ 39.00
[85025&305] Automated hemogram (CBC) & LAB/HEMATOLOGY	PPO Benefits applied.	Laboratory Test	$ 60.00	$ 39.00
[70100&320] X-ray exam of jaw, partial & DX X-RAY	PPO Benefits applied.	Diagnostic Xray/Lab	$ 235.00	$ 152.75
[70355&320] Orthopantogram , eg panoramic x-ray & DX X-RAY	PPO Benefits applied.	Diagnostic Xray/Lab	$ 235.00	$ 152.75
[71020&324] Chest x-ray, two views & DX X-RAY CHEST	PPO Benefits applied.	Diagnostic Xray/Lab	$ 242.00	$ 157.30
[70486&351] CAT scan of face, jaw & CT SCAN/HEAD	PPO Benefits applied.	CT Scans	$ 1,021.00	$ 663.65
[99284-25&450] Emergency dept visit, high & EMERGENCY ROOM	PPO Benefits applied.	Emergency Room Visit	$ 2,600.00	$ 1,690.00
[93306&483] TTE W/DOPPLER, COMPLETE & ECG	PPO Benefits applied.	Cardiology	$ 2,265.00	$ 1,472.25
[93005&730] Electrocardiogram, tracing only & EKG/ECG	PPO Benefits applied.	Echocardiograph	$ 137.00	$ 89.05
			$ 6,855.00	$ 4,455.75

9999999	Inmate_Last_Name, BRIAN	2013-030003296-0000	01/30/13	12/14/12-12/14/12	To Be Paid	02/15/13	22	PrimeHealth Services Inc.

Procedure(s): [CPT &/or UB-92]	Adjudication Notes	Coverage Code	Billed	Paid
[710] RECOVERY ROOM	PPO Benefits applied.	Hospital Services	$ 878.00	$ 570.70
			$ 878.00	$ 570.70

Vendor: UTMB AT GALVESTON [746000949]

XX01-14XX	Last_Name, ANDREW	2013-030003306-0000	01/30/13	12/28/12-12/28/12	Check # here	02/15/13	22	PrimeHealth Services Inc.

Procedure(s): [CPT and/or UB-92]	Adjudication Notes	Coverage Code	Billed	Paid
[80048&301] Metabolic panel, basic & LAB/CHEMISTRY	PPO Benefits applied.	Laboratory Test	$ 60.00	$ 39.00
[85025&305] Automated hemogram (CBC) & LAB/HEMATOLOGY	PPO Benefits applied.	Laboratory Test	$ 60.00	$ 39.00
[70100&320] X-ray exam of jaw, partial & DX X-RAY	PPO Benefits applied.	Diagnostic Xray/Lab	$ 235.00	$ 152.75
[70355&320] Orthopantogram , eg panoramic x-ray & DX X-RAY	PPO Benefits applied.	Diagnostic Xray/Lab	$ 235.00	$ 152.75
[71020&324] Chest x-ray, two views & DX X-RAY CHEST	PPO Benefits applied.	Diagnostic Xray/Lab	$ 242.00	$ 157.30
[70486&351] CAT scan of face, jaw & CT SCAN/HEAD	PPO Benefits applied.	CT Scans	$ 1,021.00	$ 663.65
[99284-25&450] Emergency dept visit, high & EMERGENCY ROOM	PPO Benefits applied.	Emergency Room Visit	$ 2,600.00	$ 1,690.00
[93306&483] TTE W/DOPPLER, COMPLETE & ECG	PPO Benefits applied.	Cardiology	$ 2,265.00	$ 1,472.25
[93005&730] Electrocardiogram, tracing only & EKG/ECG	PPO Benefits applied.	Echocardiograph	$ 137.00	$ 89.05
			$ 6,855.00	$ 4,455.75

XX01-26XX	Last_Name, BRIAN	2013-030003296-0000	01/30/13	12/14/12-12/14/12	Check # here	02/15/13	22	PrimeHealth Services Inc.

Procedure(s): [CPT and/or UB-92]	Adjudication Notes	Coverage Code	Billed	Paid
[710] RECOVERY ROOM	PPO Benefits applied.	Hospital Services	$ 878.00	$ 570.70
			$ 878.00	$ 570.70

CLAIMS DEPARTMENT HANDBOOK

On the following pages is a copy of the claims department training materials for our Kentucky book of business. Similar materials exist for each client and are developed for any new client.

correctional

CorrectCare
INTEGRATED HEALTH™

CorrectCare - Integrated Health

Claims Department

Training Manual

www.correctcare.com

CorrectCare INTEGRATED HEALTH	Policy Number 1.0	Page 1
	Date Issued November 15, 2006	Revision Date

Policy: 1083 Department of Corrections Processing Guidelines
Provider Network: Bluegrass Family Health 5/18/06 -12/31/2007
Healthlink 1/1/2008 - Current

Group Effective Date: 10/15/03	Approved By

I. PURPOSE

To provide inmate medical claim processing guidelines for KY Department of Corrections to render payment to the providers of service.

II. APPLICABILITY

This policy shall be applicable to all employees involved with the claim processing for KY Department of Corrections inmate services.

III. POLICY

To establish medical claim processing guidelines for KY Department of Corrections inmate claims.

IV. PROCEDURES

A. Eligibility

The inmate eligibility and location are to be verified in DOC1, listed below is the location listing name and address.

Location	Institution Name	Population
100	Bell County Forestry Camp Route 2, Box 75 Pineville, KY 40977 Phone. 606-337-7065	Male
101	Blackburn Correctional Complex 3111 Spurr Road Lexington, KY 40511 Phone. 859-246-2366	Male
102	Eastern Kentucky Correctional Complex 300 Road to Justice West Liberty, KY 41472 Phone. 606-743-2800	Male

CorrectCare INTEGRATED HEALTH	Policy Number 1.0	Page 2
	Date Issued November 15, 2006	Revision Date

Policy: 1083 Department of Corrections Processing Guidelines
Provider Network: Bluegrass Family Health 5/18/06 -12/31/2007
Healthlink 1/1/2008 - Current

Group Effective Date: 10/15/03	Approved By

103	Frankfort Career Development Center PO Box 538 Frankfort, KY 40602 Phone. 502-564-2120	Male
104	Green River correctional Complex PO Box 9300 Central City, KY 42330-9300 Phone. 270-754-5415	Male
105	KY Correctional Institute for Women PO Box 337 Pewee Valley, KY 40056-0337 Phone. 502-2411-8454	Female
106	KY State Penitentiary PO Box 5128 Eddysville, KY 42038-5128 Phone. 270-388-2211	Male/Female
107	Kentucky State Reformatory 3001 West Highway 146 LaGrange, KY 40032 Phone. 502-222-9441	Male
109	Luther Luckett Correctional Complex PO Box 6 LaGrange, KY 40031 Phone. 502-222-9441	Male
111	Northpoint Training Center PO Box 479 Burgin, KY 40310 Phone. 859-239-7012	Male
112	Roederer Correctional Complex PO Box 69 LaGrange, KY 40031 Phone. 502-222-0170	Male
113	Western Kentucky Correctional Complex 374 New Bethel Road Fredonia, KY 42411 Phone. 270-388-9781	Male
214	KCPC	Male/Female
215	Little Sandy Correctional Center Route 5, Box 1000 Sandy Hook, KY 41171-0000	

Inmate must have valid eligibility in DOC1 for the date of service being billed on the claim form.

If there is not valid eligibility a claim problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim. The eligibility department will verify and return to the claims department. If eligibility determines that there is not valid eligibility, the claim will be returned to the billing provider with a coversheet indicating the reason we cannot process the claim. (Attachment B). The form returned from eligibility will be filed in the claim return folder located in the claim file cabinet.

B. Authorizations

A valid authorization must exist in DOC1 for the services being rendered. Verify the following information on the authorization before processing the claim for payment.

Inmate Name
Inmate Number
Inmate Location
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before processing the claim for payment; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a claim problem log sheet (Attachment A) will need to be

completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

C. Exception Processing

The following providers/services are paid without an authorization as long as there is valid eligibility.

Dr. Schulten & Harris-Dental
Tyson, Schwab-all place of service except inpatient.
Ted Richardson-Vision
ER visits prior to 11/15/05
Lab Services

999

I. PURPOSE

To provide inmate medical claim processing guidelines for KY Department of Corrections state inmates being housed at county jails to render payment to the providers of service.

II. APPLICABILITY

This policy shall be applicable to all employees involved with the claim processing for KY Department of Corrections inmate services.

III. POLICY

To establish medical claim processing guidelines for KY Department of Corrections for state inmates being housed in county jail facilities.

IV. PROCEDURES

The 999 group is for state inmates that are being housed in county jail facilities. There are 2 types of processes for the 999 group, services that are paid under the group and services that are repriced only.

A. Services Paid

Inpatient Stays and all related charges that include but is not limited to Physician charges, lab charges, anesthesia charges, Emergency Room charges if the visit results in a Inpatient admission.

Surgery that requires any type of anesthesia, this includes any type of Oral Surgery procedures.

Claims are only to be processed to pay when the plan is set to claim type of 5.

B. Reprice Services

All services that are not related to an Inpatient Admission or a surgery with anesthesia. This can include but is not limited to Office Visits,

diagnostic services, Emergency Room, and Observation room. These are repriced only and returned to jail facility to issue payment.

If the inmate is a county inmate the claim will be returned to the provider, county inmate claims are not repriced. The only exception to this rule is if the county inmate is in a jail that we process their claims for payment.

Claims are only to be processed to pay when the plan is set to plan override of 5.

No claims are repriced for the following jail facilities, there are individual contracts with these jails to process their claims for payment. These will be processed according to their group guidelines.

Group #	Group Name	Effective Date
18	Calloway County Detention Center	Terminated
19	Campbell County Detention Center	Terminated 1/31/07
41	Grant County Detention Center	8/1/04-Termed 7/1/2005
59	Kenton County Detention Center	Terminated 6/30/08
120	Woodford County Detention Center	5/1/2004-terminated

B. Eligibility

The inmate eligibility and location are to be verified in DOC1 for claims that are to be processed and paid under this group. If the service is a reprice only we can use the jail location if shown on the claim form as proof of eligibility. Listed below is the location listing, name and address.

Services that are paid under 999 group .

Inmate must have valid eligibility listing jail location in DOC1 for the date of service being billed on the claim form.

If there is not valid eligibility a Claim Problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim. The eligibility

department will verify these and return to the claims department. If the eligibility department determines that there is not valid eligibility, the claim will be returned to the billing provider with a coversheet indicating the reason we cannot process the claim. (Attachment B). The form returned from eligibility will be filed in the claim return folder located in the claim file cabinet.

C. Authorizations

A valid authorization must exist in DOC1 for the services being rendered if the inmate is a state inmate being housed a county jail facility and the claim is for Inpatient admission, or Surgery with Anesthesia. Verify the following information on the authorization before processing the claim for payment.

Inmate Name
Inmate Number
Inmate Location
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before processing the claim for payment; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a Claim Problem log sheet (Attachment A) will need to be completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

I. PURPOSE

To provide inmate medical claim processing guidelines for Kenton County Detention Center to render payment to the providers of service.

II. APPLICABILITY

This policy shall be applicable to all employees involved with the claim processing for Kenton County Detention Center.

III. POLICY

To establish medical claim processing guidelines for Kenton County Detention Center medical claims.

IV. PROCEDURES

A. Eligibility

The inmate eligibility and location are to be verified in DOC1, listed below is the location listing name and address.

Inmate must have valid eligibility in DOC1 for the date of service being billed on the claim form.

If there is not valid eligibility a Claim Problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim. The eligibility department will verify these and return to the claims department. If the eligibility department determines that there is not valid eligibility, the claim will be returned to the billing provider with a coversheet indicating the reason we cannot process the claim. (Attachment B). The form returned from eligibility will be filed in the claim return folder located in the claim file cabinet.

B. Authorizations

A valid authorization must exist in DOC1 for the services being rendered. Verify the following information on the authorization before processing the claim for payment.

Inmate Name
Inmate Number
Inmate Location
Inmate Type-County or State
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before processing the claim for payment; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a Claim Problem log sheet (Attachment A) will need to be completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

C. Inmate Types

County Inmates

All claim types are processed for county inmates under this group for Payment.

State Inmates

Inpatient stays and all related services and Outpatient surgery with anesthesia

CorrectCare INTEGRATED HEALTH	Policy Number 1.7	Page 3
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Policy: 59 Kenton County Detention Center Processing Guidelines		
Group Effective Date: 11/1/04	Approved By:	

are processed under Group 999 for payment if the inmate is a state inmate. The state is responsible for payment on these services.

CorrectCare INTEGRATED HEALTH	Policy Number 1.0	Page 1
	Date Issued June 30, 2007	Revision Date
Policy: 191 County Inmate Re-price		
Group Effective Date: 7/1/2007	Approved By	

I. AUTHORITY

This policy and procedure is issued under the authority of the Governing Board of CorrectCare, Inc. in order to adopt rules and regulations for Claims administration.

II. PURPOSE

To provide guidelines for claims processing for County Inmate claims.

III. APPLICABILITY

This policy shall be applicable to all employees in the claims administration department.

IV. DEFINITIONS

Repriced Claim- A claim that has been processed with the allowed amounts to be paid to the provider who rendered the services. The county where the inmate was housed at the time of the date of service is responsible for check issue to the provider.

V. POLICY

All claims received on county inmates will be repriced and returned to the jail which is responsible for payment to the providers effective July 1, 2007. Group 191 has been setup for claims processing for county inmates housed in county jail facilities.

The group listed below are an exception to the above, this jail has a full service contracts with Correctcare for claims administration. This group will be processed according to the group specific guidelines.

CorrectCare INTEGRATED HEALTH	Policy Number 1.0	Page 2
	Date Issued June 30, 2007	Revision Date
Policy: 191 County Inmate Re-price		
Group Effective Date: 7/1/2007	Approved By	

Group #	Group Name	Effective Date
59	Kenton County Detention Center	11/1/04 Terminated 5/18/08

ELIGIBILITY

Eligibility data will not be received from the jails and detention centers. Verification will be completed to verify the inmate is not a state inmate that is being housed at a county jail or detention center.

Listed below is a listing of all jails and detention centers.

1. A lookup will be done in the DOC1 application by Name, SSN, or Inmate ID number received on the claim. If there is not valid eligibility listed in DOC1 a Claim Problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim.

2. The eligibility department will verify eligibility in the Frankfort office. If eligibility determines the inmate is a state inmate, the claim will be processed under the state inmate group 999 according to the guidelines.

3. If eligibility determines the inmate is not a state inmate, the claim will be processed under the county inmate group 191.

4. Once determined the inmate is a county inmate, eligibility will be loaded into the WLT claim system.

   Inmate will be added to group 191 County Inmate Plan using the date of service on claim received for the effective date. Inmate must have a valid SSN in order to be added.

   The jail claim form should be attached to the claim and will list the jail name and number. If this is not attached the information can be taken from the provider claim form received. Select the appropriate location from the drop down box in the eligibility screen and post the record.

If the claim does not have the claim form attached or a jail location determination cannot be made the claim image will be printed and returned to the provider requesting the inmate location. (Attachment B) The claim cannot be processed without the jail location.

If the jail location cannot be determined, the claim will be returned to the Provider to request the location of the county inmate. A copy of the claim Will be filed in the folder for returned county inmate claims.

AUTHORIZATIONS

A valid authorization must exist for the services being rendered if the inmate is a county inmate housed a county jail facility and the claim is for Inpatient admissions, or Outpatient Surgery with Anesthesia. Verify the following information on the authorization before repricing the claim.

Inmate Name
Inmate Number
Inmate Location
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before repricing the claim; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a Claim Problem log sheet (Attachment A) will need to be completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

HB191-CATASTROPHIC

Central office will notify Correctcare when a county inmate is deemed Catastrophic. During the time frame as catastrophic, the department of corrections will Pay all claims for the county inmate. The inmate eligibility record will be setup to indicate the inmate is Catastrophic.

When the county inmate is catastrophic all services will require authorization.

When the claims are processed a plan override of 7 will be used on the claim.

It is very important to read all memo's on the eligibility records on the County inmates.

CLAIM PROCESSING

Claims for Inpatient stays or Outpatient services with Anesthesia do require a authorization before the reprice is completed. All re-price claims will be processed as no check claims.

The following need to be completed when the claim has been re-priced prior to claim being returned to the jail.

A. Claim pre-processing sheet will be printed.
B. Claim form image to be printed from image website.
C. Re-price cover sheet to be completed. (Attachment C)

The re-price cover sheet will be completed for each claim, this needs to be placed on top with the re-price sheet, and the claim form. These will be placed in the County group tray for mailing.

MAILING

Claims will be returned to the Jails/Detention Centers on Tuesday and Friday of each week.

All re-priced claims will be sorted by jail location, and a coversheet for each jail will be placed with their claims and mailed to the jail address listing attached. (Attachment D)

Approved by: _____ **Date:** _____

Approved by: _____ **Date:** _____

The attached claim has been re-priced using the Kentucky Correctional Health Services Network (KCHSN), which has access to the Healthlink Network. The allowed amount below will need to be paid to the provider in 30 days of the receipt date.

Jail facility is responsible to verify inmate eligibility on the re-priced claim attached.

INMATE NAME_____

DATE OF SERVICE_____

PROVIDER NAME_____

BILLED AMOUNT ON CLAIM_____

DISCOUNT SAVINGS_____

ALLOWED AMOUNT _____

NOTE:
If payment is not made to within 30 days of receipt date, according to the provider contract this provider holds with the Healthlink network, the discount savings above will not be accepted and the billed amount shown must be paid.

The attached claim has been re-priced using the Kentucky Correctional Health Services Network (KCHSN), which has access to the Bluegrass Family Health Network (BFH). The allowed amount below will need to be paid to the provider in 30 days of the receipt date.

Jail facility is responsible to verify inmate eligibility on the re-priced claim attached.

INMATE NAME_____

DATE OF SERVICE_____

PROVIDER NAME_____

BILLED AMOUNT ON CLAIM_____

DISCOUNT SAVINGS_____

ALLOWED AMOUNT _____

NOTE:
If payment is not made to within 30 days of receipt date, according to the provider contract this provider holds with the Bluegrass Family Health Network, the discount savings above will not be accepted and the billed amount shown must be paid.

April 18, 2007

Dear Provider:

Effective with July 1, 2007 dates of service all county inmates in jails, detention centers and halfway houses will access the Kentucky Correctional Health Services Network (KCHSN). All members of the KCHSN will have access to the Bluegrass Family Health Network (BFH). With this change all medical claims associated with incarcerated inmates will be sent to Correctcare, Inc. All claims received that are associated with county inmates will be re-priced using the KCHSN and returned to the jail, detention center and halfway house. The facility will assume payer responsibility unless it is a jail that has a full service contract with Correctcare. The repriced claims will be returned on Tuesday and Thursday of each week to these facilities.

A Correctcare claim form will be sent with the inmate when the inmate leaves the facility for medical care and treatment. Please attach the claim form to each claim submission and submit to the P.O. Box listed below. This form is an important part of the eligibility process and indicates where the inmate is being housed. Also include the name of the jail on the HCFA 1500 or UB claim form submitted. Claims received without the jail information will be returned to the provider office for the jail location. Claims questions should be directed to Correctcare. Do not submit claims to Bluegrass Family Health, jails, detention centers and halfway houses. The correct billing and contact information are as follows:

Claim Submission

CorrectCare
P.O. Box 22219
Lexington, KY 40522

Claim Questions/Customer Service
Local (Lexington): (859) 225-7999
Toll Free Telephone: (877) 292-7999

Thank you for your continued participation with KCHSN. Please call Correctcare with any questions or concerns you may have.

Sincerely,

Thank you for your claim submission to CorrectCare, Inc., the enclosed claim is being returned for the reasons indicated below.

_____Claim does not have Jail claim form attached showing jail location.

_____Patient was not a state or county inmate on date of service.

_____Claim not submitted on a standard HCFA 1500/UB92 form.

_____Claim submitted with no charge amounts.

_____Claim submitted with no date of service.

_____Claim submitted with no diagnosis code or invalid code.

_____Claim submitted with no procedure code or invalid code.

_____Physicians Tax ID number not entered in box 25 on HCFA 1500

_____Physicians name not entered in box 33 on HCFA 1500

_____Physicians/Suppliers name and address not entered in box 33 on HCFA 1500

_____Other_____

_____

_____

Please return the indicated information along with the claim to ensure timely processing. Thank you in advance for your assistance in this manner. If you have questions concerning this information, please contact us at (859) 225-7999 or (877) 292-7999

Sincerely,

CorrectCare Integrated Health
Claims Department

I. PURPOSE

To provide inmate medical claim processing guidelines for CCA Lee Adjustment Center to render payment to the providers of service.

II. APPLICABILITY

This policy shall be applicable to all employees involved with the claim processing for CCA Lee Adjustment Center.

III. POLICY

To establish medical claim processing guidelines for CCA Lee Adjustment Center medical claims.

IV. PROCEDURES

A. Eligibility

The inmate eligibility and location are to be verified in DOC1, listed below is the location listing name and address.

Locations

1=Kentucky Inmate
2-Vermont Inmate

Inmate must have valid eligibility in DOC1 for the date of service being billed on the claim form.

If there is not valid eligibility a Claim Problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim. The eligibility department will verify these and return to the claims department. If the eligibility department determines that there is not valid eligibility, the claim will be returned to the billing provider with a coversheet indicating the reason we cannot process the claim. (Attachment B). The form returned from eligibility will be filed in the claim return folder located in the claim file cabinet.

B. Authorizations

Authorizations are created from a daily log received from the facility starting with dates of service September 9, 2006. This log is located on the P drive, Claims folder, CCA Daily log. Claims with dates of service after this that do not have an authorization will be denied for no prior authorization on file. These do not need to be sent to the Utilization department for review.

A valid authorization must exist in DOC1 or the CCA daily log file for the services being rendered. Verify the following information on the authorization before processing the claim for payment.

Inmate Name
Inmate Number
Inmate Location
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before processing the claim for payment; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a Claim Problem log sheet (Attachment A) will need to be completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

C. Timely Claim Submission

All claims must be filed within 180 days from the date of service starting with dates of service September 9, 2006. Claims with dates of service prior to this date can be paid without the timely claim submission limit.

D. Inpatient Hospitalizations

When claims are received for Inpatient Hospitalizations CCA requires a breakdown of charges from the hospital facility before payment can be made. If this is not attached to the claim image, deny the claim requesting the breakdown of charges. All physician charges can be paid but not the Hospital claim.

If the breakdown is attached to the image, print the image and breakdown and place in the CCA Breakdown folder located in the Claims File Cabinet, 3rd drawer. These breakdowns are provided to CCA with the Monthly Inpatient report.

I. PURPOSE

To provide inmate medical claim processing guidelines for CCA Marion Adjustment Center to render payment to the providers of service.

II. APPLICABILITY

This policy shall be applicable to all employees involved with the claim processing for CCA Lee Adjustment Center.

III. POLICY

To establish medical claim processing guidelines for CCA Marion Adjustment Center medical claims.

IV. PROCEDURES

A. Eligibility

The inmate eligibility and location are to be verified in DOC1, listed below is the location listing name and address.

Locations

1=Kentucky Inmate

Inmate must have valid eligibility in DOC1 for the date of service being billed on the claim form.

If there is not valid eligibility a Claim Problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim. The eligibility department will verify these and return to the claims department. If the eligibility department determines that there is not valid eligibility, the claim will be returned to the billing provider with a coversheet indicating the reason we cannot process the claim. (Attachment B). The form returned from eligibility will be filed in the claim return folder located in the claim file cabinet.

B. Authorizations

Authorizations are created from a daily log received from the facility starting with dates of service September 9, 2006. This log is located on the P drive, Claims folder, CCA Daily log. Claims with dates of service after this that do not have an authorization will be denied for no prior authorization on file. These do not need to be sent to the Utilization department for review.

A valid authorization must exist in DOC1 or the CCA daily log file for the services being rendered. Verify the following information on the authorization before processing the claim for payment.

Inmate Name
Inmate Number
Inmate Location
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before processing the claim for payment; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a Claim Problem log sheet (Attachment A) will need to be completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

C. Timely Claim Submission

All claims must be filed within 180 days from the date of service starting with dates of service September 9, 2006. Claims with dates of service prior to this date can be paid without the timely claim submission limit.

D. Inpatient Hospitalizations

When claims are received for Inpatient Hospitalizations CCA requires a breakdown of charges from the hospital facility before payment can be made. If this is not attached to the claim image, deny the claim requesting the breakdown of charges. All physician charges can be paid but not the Hospital claim.

If the breakdown is attached to the image, print the image and breakdown and place in the CCA Breakdown folder located in the Claims File Cabinet, 3rd drawer. These breakdowns are provided to CCA with the Monthly Inpatient report.

I. PURPOSE

To provide inmate medical claim processing guidelines for CCA Otter Creek Correctional Complex to render payment to the providers of service.

II. APPLICABILITY

This policy shall be applicable to all employees involved with the claim processing for CCA Otter Creek Correctional Complex.

III. POLICY

To establish medical claim processing guidelines for CCA Otter Creek Correctional Complex medical claims.

IV. PROCEDURES

A. Eligibility

The inmate eligibility and location are to be verified in DOC1, listed below is the location listing name and address.

Locations

1-Kentucky Inmate
2-Hawaii Inmate

Inmate must have valid eligibility in DOC1 for the date of service being billed on the claim form.

If there is not valid eligibility a Claim Problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim. The eligibility department will verify these and return to the claims department. If the eligibility department determines that there is not valid eligibility, the claim will be returned to the billing provider with a coversheet indicating the reason we cannot process the claim. (Attachment B). The form returned from eligibility will be filed in the claim return folder located in the claim file cabinet.

B. Authorizations

Authorizations are created from a daily log received from the facility starting with dates of service September 9, 2006. This log is located on the P drive, Claims folder, CCA Daily log. Claims with dates of service after this that do not have an authorization will be denied for no prior authorization on file. These do not need to be sent to the Utilization department for review.

A valid authorization must exist in DOC1 or the CCA daily log file for the services being rendered. Verify the following information on the authorization before processing the claim for payment.

Inmate Name
Inmate Number
Inmate Location
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before processing the claim for payment; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a Claim Problem log sheet (Attachment A) will need to be completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

C. Timely Claim Submission

All claims must be filed within 180 days from the date of service starting with dates of service September 9, 2006. Claims with dates of service prior to this date can be paid without the timely claim submission limit.

D. Inpatient Hospitalizations

When claims are received for Inpatient Hospitalizations CCA requires a breakdown of charges from the hospital facility before payment can be made. If this is not attached to the claim image, deny the claim requesting the breakdown of charges. All physician charges can be paid but not the Hospital claim.

If the breakdown is attached to the image, print the image and breakdown and place in the CCA Breakdown folder located in the Claims File Cabinet, 3rd drawer. These breakdowns are provided to CCA with the Monthly Inpatient report.

CODE	CATEGORY	INFORMATION TO PULL FROM WLT
528300	Hosp Inpatient	Will always have a revenue code range 100-999 and will be place of service 21
528500	Hospital Outpatient	Will always have a revenue code range 100-999 and will be place of service 22
528700	Physician Inpatient	Will have a procedure code 10000-99999 and be place of service 21
528900	Physician Outpatient	Will have a procedure code 10000-99999, D0001-D9999 and be place of service 11,22 or 23
529000	Discount/Repricing	Claim always on the excense employee #1 for the group and only has date of service, units and charge amount.
530700	Laboratory	Will have a procedure code in range of 80000-89989 and must be place of service 81
530900	Miscellaneous	Will always have coverage code AMBU and will always be place of service 41 or 42

1400

I. PURPOSE

To provide inmate medical claim processing guidelines for PHS Little Sandy Corrections Complex to render payment to providers of service.

II. APPLICABILITY

This policy shall be applicable to all employees involved with the claim processing for PHS Little Sandy Corrections Complex medical claims.

III. POLICY

To establish medical claim processing guidelines for PHS Little Sandy Correctional Complex inmate claims.

IV. PROCEDURES

A. Eligibility

The inmate eligibility and location are to be verified in DOC1, listed below is the location listing name and address.

1-Kentucky Inmates

Inmate must have valid eligibility in DOC1 for the date of service being billed on the claim form.

If there is not valid eligibility a Claim Problem log sheet (Attachment A) will need to be completed and attached to a copy of the claim. The eligibility department will verify these and return to the claims department. If the eligibility department determines that there is not valid eligibility, the claim will be returned to the billing provider with a coversheet indicating the reason we cannot process the claim. (Attachment B). The form returned from eligibility will be filed in the claim return folder located in the claim file cabinet.

B. Authorizations

A valid authorization must exist in DOC1 for the services being rendered. Verify the following information on the authorization before processing the claim for payment.

Inmate Name
Inmate Number
Inmate Location
Authorization approval dates
Type of service approved
Provider of Service
Authorization Comments
Notes
Decision

Read all authorization notes before processing the claim for payment; these notes contain information on denied days, or other special processing/denial information.

If there is not a valid authorization or there is a problem with one of the items listed above a Claim Problem log sheet (Attachment A) will need to be completed along with a claim copy and be forward to the Utilization Review Department. These will be investigated and returned to the claims department with the appropriate authorization number; or additional information will need to be requested before a determination can be made.

State Locations

Group Location	Institution Name	Population
1083 100	Bell County Forestry Camp Route 2, Box 75 Pineville, KY 40977 Phone. 606-337-7065	Male
1083 101	Blackburn Correctional Complex 3111 Spurr Road Lexington, KY 40511 Phone. 859-246-2366	Male
1083 102	Eastern Kentucky Correctional Complex 300 Road to Justice West Liberty, KY 41472 Phone. 606-743-2800	Male
1083 103	Frankfort Career Development Center PO Box 538 Frankfort, KY 40602 Phone. 502-564-2120	Male
1083 104	Green River Correctional Complex PO Box 9300 Central City, KY 42330-9300 Phone. 270-754-5415	Male
1083 105	KY Correctional Institute for Women PO Box 337 Pewee Valley, KY 40056-0337 Phone. 502-2411-8454	Female
1083 106	KY State Penitentiary PO Box 5128 Eddysville, KY 42038-5128 Phone. 270-388-2211	Male/Female
1083 107	Kentucky State Reformatory 3001 West Highway 146 LaGrange, KY 40032 Phone. 502-222-9441	Male
1083 109	Luther Luckett Correctional Complex PO Box 6 LaGrange, KY 40031 Phone. 502-222-9441	Male
1083 111	Northpoint Training Center PO Box 479 Burgin, KY 40310 Phone. 859-239-7012	Male
1083 112	Roederer Correctional Complex PO Box 69 LaGrange, KY 40031 Phone. 502-222-0170	Male
1083 113	Western Kentucky Correctional Complex 374 New Bethel Road Fredonia, KY 42411 Phone. 270-388-9781	Male
1083 214	Kentucky Correctional Psychiatric Center PO Box 67 LaGrange, KY 40031	Male/Female

1083 215	Little Sandy Correctional Center Route 5, Box 1000 Sandy Hook, KY 41171	Male
18	Calloway County Detention Center 310 North Fourth Street Murray, KY 42071 Phone-270-753-6150	Male/Female
59	Kenton County Detention Center 303 Court Street Covington, KY 41011	Male/Female
120	Woodford County Detention Center 204 Beasley Drive Versailles, KY 40383	Male/Female
1100 VT & KY	CCA-LAC Lee Adjustment Center 2648 Fairground Ridge Road PO Box 900 Beattyville, KY 41311 606-464-2866	Male
1200 KY	CCA-MAC Marion Adjustment Center 95 Raywick Road St Mary, KY 40063	Male
1300 HI KY	CCA-OCCC Otter Creek Correctional Center Highway 306, PO Box 500 Wheelwright, KY 41669-0500	Female

Jail Locations

Jail Name	Jail #
Adair County Regional Jail	001
Allen County Jail	002
Anderson County Jail	003
Ballard County Jail	004
Barren County Jail	005
Bath County Jail	006
Bell County Jail	007
Boone County Jail	008
Bourbon County Detention Center	009
Boyd County Detention Center	010
Boyle County Detention Center	011
Bracken County Jail	012
Breathitt County Jail	013
Breckinridge County Jail	014
Bullit County Jail	015
Butler County Jail	016
Caldwell County Jail	017
Calloway County Jail	018
Campbell County Detention Center	019
Carlisle County Jail	020
Carroll County Detention Center	021
Carter County Jail	022
Casey County Jail	023
Christian County Jail	024
Clark County Detention Center	025
Clay County Jail	026
Clinton County Jail	027
Crittenden County Jail	028
Cumberland County Jail	029
Daviess County Detention Center	030
Edmonson County Jail	031
Elliott County Jail	032
Estill County Jail	033
Fayette County Detention Center	034
Fleming County Jail	035
Floyd County Jail	036
Franklin County Regional Jail	037
Fulton County Detention Center	038
Gallatin County Jail	039
Garrard County Jail	040
Grant County Jail	041
Graves County Jail	042
Grayson County Jail	043
Green County Jail	044
Greenup County Detention Center	045
Hancock County Jail	046
Hardin County Detention Center	047
Harlan County Jail	048
Harrison County Jail	049
Hart County Jail	050
Henderson County Detention Center	051
Henry County Jail	052
Hickman County Jail	053
Hopkins County Detention Center	054
Jackson County Jail	055
Jefferson County Detention Center	056
Jessamine County Detention Center	057
Johnson County Jail	058
Kenton County Detention Center	059
Knott County Jail	060

Jail Name	Jail #
Knox County Detention Center	061
Larue County Jail	062
Laurel County	063
Lawrence County Jail	064
Lee County Jail/Three Forks	065
Leslie County Jail	066
Letcher County Jail	067
Lewis County Jail	068
Lincoln County Jail	069
Livingston County Jail	070
Logan County Jail	071
Lyon County Jail	072
McCracken County Jail	073
McCreary County Jail	074
McLean County Jail	075
Madison County Detention Center	076
Magoffin County Jail	077
Marion County Jail	078
Marshall County Detention Center	079
Martin County Jail	080
Mason County Detention Center	081
Meade County Jail	082
Menifee County Jail	083
Mercer County Jail	084
Metcalfe County Jail	085
Monroe County Jail	086
Montgomery County Regional Jail	087
Morgan County Jail	088
Muhlenberg County Jail	089
Nelson County Detention Center	090
Nicholas County Jail	091
Ohio County Jail	092
Oldham County Jail	093
Owen County Jail	094
Owsley County Jail	095
Pendleton County Jail	096
Perry County Jail/Ky River	097
Pike County Detention Center	098
Powell County Jail	099
Pulaski County Detention Center	100
Robertson County Jail	101
Rockcastle County Jail	102
Rowan County Detention Center	103
Russell County Jail	104
Scott County Detention Center	105
Shelby County Detention Center	106
Simpson County Jail	107
Spencer County Jail	108
Taylor County Jail	109
Todd County Jail	110
Trigg County Jail	111
Trimble County Jail	112
Union County Jail	113
Warren County Regional Jail	114
Washington County Jail	115
Wayne County Jail	116
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LOCAL OFFICIALS LISTING

COUNTY	JAIL ADDRESS		PHONE #
ADAIR COUNTY Regional Jail	204 Greensburg Street Columbia, KY 42728		
Judge/Executive:	Ann Melton		(270) 384-4703
		FAX	(270) 384-9754
Jailer:	William A. Knight		(270) 384-5701
		FAX	(270) 384-1036
ALLEN County Jail	196 Woods St. Scottsville, KY 42164		
Judge/Executive:	Bobby Young		(270) 237-3631
		FAX	(270) 237-9155
Jailer:	Larry Piper		(270) 237-3226
		FAX	(270) 237-4393
ANDERSON County Jail	151 S. Main Street, Courthouse Lawrenceburg, KY 40342		
Judge/Executive:	Steve L. Cornish		(502) 839-3471
		FAX	(502) 839-8151
Jailer:	Lyjona A. "Joani" Clark		(502) 839-6040
		FAX	(502) 839-9333
BALLARD County Jail	P.O. Box 545 Wickliffe, KY 42087		
Judge/Executive:	Vickie L. Viniard		(270) 335-3531
		FAX	(270) 335-3010
Jailer:	Mike Horn		(270) 335-3691
		FAX	(270) 335-5225
BARREN County Jail	107 Ford Drive Glasgow, KY 42141		
Judge/Executive:	Davie D. Greer		(270) 651-8560
		FAX	(270) 651-2844
Jailer:	Leland E. Cox		(270) 651-8806
		FAX	(270) 651-7717
BATH County Jail	P.O. Box 115 - Gudgell Avenue Owingsville, KY 40360		
Judge/Executive:	Walter B. Shrout		(606) 674-6346
		FAX	(606) 674-6658
Jailer:	Palmer "Jaybird" Crouch		(606) 674-2713
		FAX	(606) 674-2341
BELL County Jail	P.O. Box 478 Pineville, KY 40977		
Judge/Executive:	Albey Brock		(606) 337-3076
		FAX	(606) 337-9807
Jailer:	James Junior Hoskins		(606) 337-2170
		FAX	(606) 337-6296
BOONE County Jail	3200 Conrad Lane Burlington, KY 41005		
Judge/Executive:	Gary W. Moore		(859) 334-2240
		FAX	(859) 334-3105
Jailer:	Edward Prindle		(859) 334-2178
		FAX	(859) 334-2296
BOURBON COUNTY Detention Center	101 Legion Road Paris, KY 40361		
Judge/Executive:	Donnie R. Foley		(859) 987-2135
		FAX	(859) 987-2136
Jailer:	Mark Matthews, Acting		(859) 987-2137
		FAX	(859) 987-2138
BOYD COUNTY Detention Center	P.O. Box 455 - Louisa Street Catlettsburg, KY 41129		
Judge/Executive:	William "Bud" Stevens		(606) 739-4134
		FAX	(606) 739-5446
Jailer:	Joe Burchett		(606) 739-4224
		FAX	(606) 739-8257

BOYLE COUNTY Detention Center	1860 S. Danville Bypass Danville, KY 40422		
Judge/Executive:	Anthony "Tony" Wilder		(859) 238-1127
		FAX	(859) 238-1108
Jailer:	Barry Harmon		(859) 238-1127
		FAX	(859) 238-1126
BRACKEN County Jail	Bracken County Courthouse Brooksville, KY 41004		
Judge/Executive:	Gary L. Riggs		(606) 735-2300
		FAX	(606) 735-2615
Jailer:	James Cox		(606) 735-3233
		FAX	(606) 735-3478
BREATHITT County Jail	1023 College Avenue Jackson, KY 41339		
Judge/Executive:	Harvey Jason Richardson		(606) 666-5472
		FAX	(606) 666-3824
Jailer:	James Elliott Turner		(606) 666-3800
		FAX	(606) 666-3821
BRECKINRIDGE County Jail	P.O. Box 486 – 500 Glen Nash Rd Hardinsburg, KY 40143		
Judge/Executive:	Ray Powers		(270) 756-2269
		FAX	(270) 756-2364
Jailer:	Allen Shrewsberry		(270) 756-6244
		FAX	(270) 756-6345
BULLITT County Jail	Box 216 Shepherdsville, KY 40165		
Judge/Executive:	Melanie J. Roberts		(502) 543-2262
		FAX	(502) 543-1577
Jailer:	Danny Fackler		(502) 543-7263
		FAX	(502) 291-2772

BUTLER County Jail	P.O. Box 609 Morgantown, KY 42261		
Judge/Executive:	David Fields		(270) 526-3433
		FAX	(270) 526-2658
Jailer:	Terry M. Fugate		(270) 526-3505
		FAX	(270) 526-3757
CALDWELL County Jail	111 East Market Street - Room 7 Princeton, KY 42445		
Judge/Executive:	Van Knight		(270) 365-6660
		FAX	(270) 365-6637
Jailer:	Jim Blackburn		(270) 365-6790
		FAX	(270) 365-6790
CALLOWAY County Jail	310 North Fourth Street Murray, KY 42071		
Judge/Executive:	Larry Elkins		(270) 753-2920
		FAX	(270) 753-1433
Jailer:	Phil Hazle		(270) 753-6150
		FAX	(270) 759-5140
CAMPBELL COUNTY Detention Center	601 Central Avenue Newport, KY 41071		
Judge/Executive:	Steven Pendery		(859) 292-3838
		FAX	(859) 292-3888
Jailer:	Greg L. Buckler		(859) 431-4611
		FAX	(859) 431-3123
CARLISLE County Jail	Bardwell, KY 42023		
Judge/Executive:	John G. Roberts III		(270) 628-5451
		FAX	(270) 628-0190
Jailer:	Ronny E. Owens		(270) 628-5420

CARROLL COUNTY Detention Center	800 Clay Street Carrollton, KY 41008		
Judge/Executive:	Harold "Shorty" Tomlinson		(502) 732-4426
		FAX	(502) 732-7023
Jailer:	Michael W. Humphrey		(502) 732-9499
		FAX	(502) 732-9544
CARTER County Jail	13 Crossbar Road Grayson, KY 41143		
Judge/Executive:	Charles Wallace		(606) 474-5366
		FAX	(606) 474-6991
Jailer:	Randy Binion		(606) 475-1606
		FAX	(606) 475-1677
CASEY County Jail	P. O. Box 382 Liberty, KY 42539		
Judge/Executive:	Ronald D. Wright		(606) 787-6154
		FAX	(606) 787-6154
Jailer:	Tommy L. Miller		(606) 787-9567
		FAX	(606) 787-1478
CHRISTIAN County Jail	410 West Seventh Street Hopkinsville, KY 42240		
Judge/Executive:	Steve Tribble		(270) 887-4100
		FAX	(270) 885-7501
Jailer:	Bradley L. Boyd		(270) 887-4152
		FAX	(270) 887-4450
CLARK COUNTY Detention Center	30 Wall Street Winchester, KY 40391		
Judge/Executive:	Henry Branham		(859) 745-0200
		FAX	(859) 745-4251
Jailer:	Bobby W. Stone		(859) 745-0270
		FAX	(859) 745-0271

CLAY County Jail	67 Shamrock Road Manchester, KY 40962		
Judge/Executive:	Carl "Crawdad" Sizemore		(606) 598-2071
		FAX	(606) 598-7849
Jailer:	Kenneth Price		(606) 598-
2133			
		FAX	(606) 598-7012
CLINTON County Jail	314 Cumberland Street Albany, KY 42602		
Judge/Executive:	Lyle K. Huff		(606) 387-5234
		FAX	(606) 297-7651
Jailer:	Gene Ferrill		(606) 387-8366
		FAX	(606) 387-6751
CRITTENDEN County Jail	209 South Maple Street Marion, KY 42064		
Judge/Executive:	Fred Brown		(270) 965-5251
		FAX	(270) 652-5252
Jailer:	Rick Riley		(270) 965-3185
		FAX	(270) 965-1502
CUMBERLAND County Jail	Burkesville, KY 42717		
Judge/Executive:	Tim Hicks		(270) 864-3444
		FAX	(270) 864-5884
Jailer:			(270) 864-1206
			(270) 459-0098 cell
DAVIESS COUNTY Detention Center	3337 Hwy 60 E Owensboro, KY 42303		
Judge/Executive:	Louis Reid Haire		(270) 685-8424
		FAX	(270) 685-8469
Jailer:	David W. Osborne		(270) 685-8361
		FAX	(270) 685-8449

EDMONSON County Jail	512 S. Main Street, Courthouse Brownsville, KY 42210		
Judge/Executive:	N. E. Reed		(270) 597-2819
		FAX	(270) 597-2494
Jailer:	Bruce Logsdon		(270) 597-2417
ELLIOTT County Jail	Elliott County Courthouse Sandy Hook, KY 41171		
Judge/Executive:	David Blair		(606) 738-5335
		FAX	(606) 738-4509
Jailer:	Charles Howard		(606) 738-4247
ESTILL County Jail	103 Court Street Irvine, KY 40336		
Judge/Executive:	Wallace C. Taylor		(606) 723-7524
		FAX	(606) 723-5471
Jailer:	James "Jim" Morris		(606) 723-4265
		FAX	(606) 723-6362
FAYETTE COUNTY Detention Center	600 Old Frankfort Circle Lexington, KY 40510		
Mayor:	Mayor Jim Newberry		(859) 258-3100
		FAX	(859) 252-4476
Jail Director:	Ronald L. Bishop		(859) 425-2600
		FAX	(859) 425-2795
FLEMING County Jail	115 West Main Street Flemingsburg, KY 41041		
Judge/Executive:	Larry H. Foxworthy		(606) 845-8801
		FAX	(606) 845-0212
Jailer:	Gary Conley		(606) 845-5011
FLOYD County Jail	151 South Central Avenue Prestonsburg, KY 41653		
Judge/Executive:	R.D. "Doc" Marshall		(606) 886-9193
		FAX	(606) 886-1083
Jailer:	Roger L. Webb		(606) 886-8021
		FAX	(606) 886-9950

FRANKLIN COUNTY Regional Jail	400 Coffee Tree Road- P.O. Box 4068 Frankfort, KY 40604		
Judge/Executive:	Ted Collins		(502) 875-8751
		FAX	(502) 875-8755
Jailer:	Billy Roberts		(502) 875-7398
		FAX	(502) 875-8713
FULTON COUNTY Detention Center	2010 South 7th Street Hickman, KY 42050		
Judge/Executive:	David Gallagher		(270) 236-2594
		FAX	(270) 236-7904
Jailer:	Ricky Parnell		(270) 236-2405
		FAX	(270) 236-9140
GALLATIN County Jail	501 Sparta Pike - P.O. Box 967 Warsaw, KY 41095		
Judge/Executive:	Kenny French		(606) 567-5691
		FAX	(606) 567-4764
Jailer:	Jerry L. Webb		(606) 567-5941
GARRARD County Jail	Standford Street Lancaster, KY 40444		
Judge/Executive:	John Wilson		(606) 792-3531
		FAX	(606) 792-2010
Jailer:	Kenny Tuggle		(606) 792-2591
GRANT County Jail	212 Barnes Road Williamstown, KY 41097		
Judge/Executive:	Darrell L. Link		(859) 823-7561
		FAX	(859) 823-1871
Jailer:	Steven L. Kellum		(859) 824-5191
		FAX	(859) 824-1285
GRAVES County Jail	150 Jenkins Street Mayfield, KY 42066		
Judge/Executive:	Tony Smith		(270) 247-3626
		FAX	(270) 247-1274
Jailer:	Randy Haley		(270) 247-4373
		FAX	(270) 247-9856

GRAYSON County Jail	320 Shaw Station Road Leitchfield, KY 42754		
Judge/Executive:	Gary Logsdon		(270) 259-3159
		FAX	(270) 259-0512
Jailer:	Darwin Dennison		(270) 259-3636
		FAX	(270) 259-1748
GREEN County Jail	101 South First Street Greensburg, KY 42743		
Judge/Executive:	Mary Ann Blaydes Baron		(270) 932-4024
		FAX	(270) 932-3635
Jailer:	James Arthur Henderson		(270) 932-5634
GREENUP COUNTY Detention Center	100 Laurel Street Greenup, KY 41144		
Judge/Executive:	Robert W. Carpenter		(606) 473-6440
		FAX	(606) 473-9878
Jailer:	Jim Womack		(606) 473-9660
		FAX	(606) 473-6080
HANCOCK County Jail	P.O. Box 273 Hawesville, KY 42348		
Judge/Executive:	Jack B. McCaslin		(270) 927-8137
		FAX	(270) 927-8138
Jailer:	Roger Estes		(270) 927-8770
		FAX	(270) 927-6819
HARDIN COUNTY Detention Center	P.O. Box 1390-100 Lawson Lane Elizabethtown, KY 42702-1390		
Judge/Executive:	Harry Berry		(270) 765-2350
		FAX	(270) 737-5590
Jailer:	Louis B. Lawson		(270) 765-4159 or 737-3538
		FAX	(270) 769-0248

HARLAN County Jail	6000 Hwy 38 Evarts, KY 40828		
Judge/Executive:	Joseph A. Grieshop		(606) 573-2600
		FAX	(606) 573-3522
Jailer:	Kurt Stallard		(606) 837-0269
		FAX	(606) 837-0215
HARRISON County Jail	Main Street Cynthiana, KY 41031		
Judge/Executive:	Alex Barnett		(859) 234-8376
		FAX	(859) 234-6647
Jailer:	Larry Turner		(859) 234-2367
HART County Jail	P.O. Box 670 Munfordville, KY 42765		
Judge/Executive:	Terry L. Martin		(270) 524-5219
		FAX	(270) 524-9732
Jailer:	Keith Riordan		(270) 524-2571
		FAX	(270) 524-2570
HENDERSON COUNTY Detention Center	380 Borax Drive Henderson, KY 42420		
Judge/Executive:	Sandy Lee Watkins		(270) 826-3971
		FAX	(270) 827-6002
Jailer:	Ron Herrington		(270) 827-5560
		FAX	(270) 830-9080
HENRY County Jail	P.O. Box 202 New Castle, KY 40050		
Judge/Executive:	John Logan Brent		(502) 845-2891
		FAX	(502) 845-5743
Jailer:	J. C. Suter		(502) 845-2520

HICKMAN County Jail	P. O. Box 260 Clinton, KY 42031		
Judge/Executive:	Gregory Pruitt		(270) 653-4369
		FAX	(270) 653-4248
Jailer:	Chad Frizzell		(270) 653-9933
		FAX	(270) 653-9955
		Sheriff:	(270) 653-2241

HOPKINS COUNTY Detention Center	2250 Laffoon Trail, P.O. Box 1030 Madisonville, KY 42431		
Judge/Executive:	Donald Carroll		(270) 821-8294
		FAX	(270) 821-8295
Jailer:	Thomas Joe Blue		(270) 821-6704
		FAX	(270) 821-6774

JACKSON County Jail	P.O. Box 909 McKee, KY 40447		
Judge/Executive:	William O. Smith		(606) 287-8562
		FAX	(606) 287-7190
Jailer:	Ronnie Gabbard		(606) 287-7592
		FAX	(606) 287-2152

JEFFERSON COUNTY COMMUNITY CENTER PHASE I	316 East Chestnut Louisville, KY 40202		
Mayor:	Mayor Jerry E. Abramson		(502) 574-6161
Judge Executive:	Ken Herndon	FAX	(502) 574-6605
Director:	Tom D. Campbell, Chief of Corrections		(502) 574-2167

JEFFERSON COUNTY Detention Center	400 South 6th Street Louisville, KY 40202		
Mayor:	Mayor Jerry E. Abramson		(502) 574-6161
Deputy Director:	Dewayne Clark, Deputy Director		(502) 574-2167
		FAX	(502) 574-2184

JEFFERSON COUNTY COMMUNITY CORRECTIONS CENTER PHASE II	316 East Chestnut Street Louisville, KY40202		
Mayor:	Mayor Jerry E. Abramson		(502) 574-6161
Director:	Dewayne Clark, Deputy Director		(502) 574-2167

JESSAMINE COUNTY Detention Center	229 East Maple Street Nicholasville, KY 40356		
Judge/Executive:	William Cassity		(859) 885-4500
		FAX	(859) 885-2545
Jailer:	Cecil R. Moss		(859) 885-4558
		FAX	(859) 887-2624

JOHNSON	Big Sandy Regional Detention Center P.O. Box 1390 Paintsville, KY 41240		
Board of Directors:	Robert E. Castle, Chairman		(606) 297-5245
Judge Executive:	Daniel R.T. Tucker	FAX	(606) 789-2555
Administrator:	Henry Williams, Administrator		(606) 297-5245
		FAX	(606) 297-5003

KENTON COUNTY Detention Center	303 Court Street Covington, KY 41011		
Judge/Executive:	Ralph A. Drees		(859) 392-1400
		FAX	(859) 392-1412
Jailer:	Terry W. Carl		(859) 392-1701
		FAX	(859) 392-1741

KNOTT County Jail	P. O. Box 468 Hindman, KY 41822		
Judge/Executive:	Randy C. Thompson		(606) 785-5592
		FAX	(606) 785-0966
Jailer:	Eldon Hicks		(606) 785-5827

KNOX COUNTY Detention Center	103 Jail Street Barbourville, KY 40906		
Judge/Executive:	J.M. Hall		(606) 546-6192
		FAX	(606) 546-6196
Jailer:	Larry Hammons		(606) 546-6215
		FAX	(606) 546-6219

LARUE County Jail	209 West High Street Hodgenville, KY 42748		
Judge/Executive:	Tommy Turner		(270) 358-4400
		FAX	(270) 358-4528
Jailer:	Ralph Mac Trumbo		(270) 358-9876
		FAX	(270) 358-8823

LAUREL COUNTY Detention Center	206 West Fourth Street London, KY 40741		
Judge/Executive:	Lawrence Kuhl		(606) 864-4640
		FAX	(606) 864-3867
Jailer:	Jack Sizemore		(606) 878-9431
		FAX	(606) 864-2672

LAWRENCE County Jail	P.O. Box 38 Louisa, KY 41230		
Judge/Executive:	David L. Compton		(606) 638-4102
		FAX	(606) 638-0618
Jailer:	Phil Triplett		(606) 638-4312

LEE County Jail	P.O. Box G Beattyville, KY 41311		
Judge/Executive:	Steve Mays		(606) 464-4100
		FAX	(606) 464-4102
Jailer:	Corbett Dunaway		(606) 464-4145

LESLIE County Jail	P.O. Box 884 Hyden, KY 41749		
Judge/Executive:	Jimmy Sizemore		(606) 672-3200
		FAX	(606) 672-7373
Jailer:	Eugene Roberts		(606) 672-2637

LETCHER County Jail	156 Main Street Whitesburg, KY 41858		
Judge/Executive:	Jim Ward		(606) 633-2129
		FAX	(606) 633-7105
Jailer:	Donald "Don" McCall		(606) 633-5163
		FAX	(606) 633-3800

LEWIS County Jail	509 Railroad Street Vanceburg, KY 41179		
Judge/Executive:	Steve Applegate		(606) 796-2722
		FAX	(606) 796-0822
Jailer:	Tim Underwood		(606) 796-2312
		FAX	(606) 796-0622

LINCOLN County Jail	100 Lancaster Street Stanford, KY 40484		
Judge/Executive:	R. W. Gilbert		(606) 365-2534
		FAX	(606) 365-4514
Jailer:	William "David" Gooch		(606) 365-4580
		FAX	(606) 365-2158

LIVINGSTON County Jail	P.O. Box 91 Smithland, KY 42081		
Judge/Executive:	Chris Lasher		(270) 928-2106
		FAX	(270) 928-3262
Jailer:	Benjamin Keith Guill		(270) 928-2196
		FAX	(270) 928-3606

LOGAN County Jail	304 W. Third St. Russellville, KY 42276		
Judge/Executive:	Logan Chick		(270) 726-3116
		FAX	(270) 726-3117
Jailer:	Bill Jenkins		(270) 726-3696
		FAX	(270) 726-4676

LYON County Jail	P.O. Box 903 Eddyville, KY 42038		
Judge/Executive:	Jimmy Campbell		(270) 388-7311
		FAX	(270) 388-0715
Jailer:	Hank O'Bryan		(270) 388-9502

MADISON COUNTY Detention Center	107 West Irvine Richmond, KY 40475		
Judge/Executive:	Kent Clark		(859) 624-4700
		FAX	(859) 624-9140
Jailer:	Ron Devere		(859) 624-4710
		FAX	(859) 623-8062

MAGOFFIN County Jail	P.O. Box 362 Saylersville, KY 41465		
Judge/Executive:	Charles "Doc" Hardin		(606) 349-2313
		FAX	(606) 349-2109
Jailer:	Tim Watkins		(606) 349-2860
MARION County Jail	201 Warehouse Road Lebanon, KY 40033		
Judge/Executive:	John G. Mattingly		(270) 692-3451
		FAX	(270) 692-9487
Jailer:	Barry Brady		(270) 692-5802
	cell 270-699-1096	FAX	(270) 699-9067
MARSHALL COUNTY Detention Center	204 West 5th Street Benton, KY 42025		
Judge/Executive:	Mike Miller		(270) 527-3380
		FAX	(270) 527-4795
Jailer:	Roger Ford		(270) 527-4760
		FAX	(270) 527-4745
MARTIN County Jail	P.O. Box 777 Inez, KY 41224		
Judge/Executive:	Kelly E. Callaham		(606) 298-2800
		FAX	(606) 298-4404
Jailer:	Boone Mahon		(606) 298-2112
		FAX	(606) 298-6890
MASON COUNTY Detention Center	U. S. 68, Box 702 Maysville, KY 41056		
Judge/Executive:	James Gallenstein		(606) 564-6706
		FAX	(606) 564-7315
Jailer:	Gerald Curtis		(606) 564-3621
		FAX	(606) 564-3397
McCRACKEN County Jail	400 South 7th Street Paducah, KY 42003		
Judge/Executive:	Van Elliott Newberry		(270) 444-4707
		FAX	(270) 444-4743
Jailer:	Bill Adams		(270) 444-4723
		FAX	(270) 444-4746
McCREARY County Jail	P.O. Box 426 Whitley City, KY 42653		
Judge/Executive:	Blaine Phillips		(606) 376-2413
		FAX	(606) 376-3898
Jailer:	Anthony "Tony" Ball		(606) 376-2040
		FAX	(606) 376-9063
McLEAN County Jail	P.O. Box 38 Calhoun, KY 42327		
Judge/Executive:	Larry B. Whitaker		(270) 273-3213
		FAX	(270) 273-9965
Jailer:	Mike "Red" Sallee		(270) 273-3719
MEADE County Jail	516 Fairway Drive Brandenburg, KY 40108		
Judge/Executive:	Harry Craycroft		(270) 422-3967
		FAX	(270) 422-3262
Jailer:	Troy Seelye		(270) 422-2546
		FAX	(270) 422-4016
MENIFEE County Jail	P.O. Box 105 Frenchburg, KY 40322		
Judge/Executive:	Hershell L. Sexton		(606) 768-3482
		FAX	(606) 768-2144
Jailer:	Jason Stull		(606) 768-3875
MERCER County Jail	224 South Main Street Harrodsburg, KY 40330		
Judge/Executive:	John Trisler		(606) 734-6300
		FAX	(606) 734-6345
Jailer:	Cleo Baker		(606) 734-6336
METCALFE County Jail	P.O. Box 531 Edmonton, KY 42129		
Judge/Executive:	Greg Wilson		(270) 432-3181
		FAX	(270) 670-8794
		Or	(270) 670-4301
Jailer:	Jimmy Shive		(270) 670-8794 or (270) 670-4301
MONROE County Jail	204 Crawford Street Tompkinsville, KY 42167		
Judge/Executive:	Wilbur Graves		(270) 487-5505
		FAX	(270) 487-0591
Jailer:	Elmer Doyle Fox		(270) 487-5594
		FAX	(270) 487-0511
MONTGOMERY CO. Regional Jail	751 Chenault Drive Mt. Sterling, KY 40353		
Judge/Executive:	B. D. Wilson, Jr.		(859) 498-8707
		FAX	(859) 498-1040
Jailer:	Everett D. Myers		(859) 498-8746
		FAX	(859) 498-8748
MORGAN County Jail	West Liberty, KY 41472		
Judge/Executive:	Timothy Conley		(606) 743-3898
		FAX	(606) 743-3895
Jailer:	James Easterling		(606) 743-3400
MUHLENBERG County Jail	108 Court Row Greenville, KY 42345		
Judge/Executive:	Rick Newman		(270) 338-2520
		FAX	(270) 338-6116
Jailer:	Mark Curry		(270) 338-2263
		FAX	(270) 338-2228
NELSON COUNTY Detention Center	810 West Stephen Foster Avenue – P.O. Box 280 Bardstown, KY 40004		
Judge/Executive:	Dean Watts		(502) 348-1800
		FAX	(502) 348-1873
Jailer:	Dorcas F. Figg		(502) 348-1860
		FAX	(502) 348-1853
NICHOLAS County Jail	516 East Main Street Carlisle, KY 40311		
Judge/Executive:	Larry D. Tincher		(859) 289-2404
		FAX	(859) 289-3705
Jailer:	Jeff "Bubba" Sidles		(859) 289-7582
OHIO County Jail	108 East Washington Street Hartford, KY 42347		
Judge/Executive:	David Jones		(270) 298-7629
		FAX	(270) 298-4404
Jailer:	Gerry "Rip" Wright		(270) 298-4455
		FAX	(270) 298-4451
OLDHAM County Jail	102 West Main Street LaGrange, KY 40031		
Judge/Executive:	Duane Murner		(502) 222-9357
		FAX	(502) 222-3210
Jailer:	Mike Simpson		(502) 222-3500
		FAX	(502) 222-3510
OWEN County Jail	Owenton, KY 40359		
Judge/Executive:	William P. O'Banion		(502) 484-3405
		FAX	(502) 484-1004
Jailer:	David V. Bruce		(502) 484-3363
OWSLEY County Jail	P. O. Box 472 Booneville, KY 41314		
Judge/Executive:	Cale Turner		(606) 593-6202
		FAX	(606) 593-6381
Jailer:	Hubert Shouse		(606) 593-6105
PENDLETON County Jail	210 Chapel Street Falmouth, KY 41040		
Judge/Executive:	Henry W. Bertram		(859) 654-4321
		FAX	(859) 654-5047
Jailer:	Ken Kells		(859) 654-6188
PERRY County Jail	200 Justice Drive Hazard, KY 41701		
Judge/Executive:	Denny Ray Noble		(606) 439-3699
		FAX	(606) 439-1686
Jailer:	Johnny Blair		(606) 476-8383
Jail Administrator:	Tim Kilburn		(606) 436-0622
		FAX	(606) 435-8312

PIKE COUNTY Detention Center	172 Division Street, Suite 103 Pikeville, KY 41501		
Judge/Executive:	Wayne T. Rutherford		(606) 432-6237
		FAX	(606) 432-6242
Jailer:	Rodney Scott		(606) 432-6291
		FAX	(606) 432-6219
POWELL County Jail	755 Breckinridge Street Stanton, KY 40380		
Judge/Executive:	Robert Ray Drake		(606) 663-2834
		FAX	(606) 663-2905
Jailer:	Teddy Lacy		(606) 663-6409
		FAX	(606) 663-6594
PULASKI COUNTY Detention Center	300 Hail Knob Road Somerset, KY 42501		
Judge/Executive:	Barty Bullock		(606) 678-4853
		FAX	(606) 678-8642
Jailer:	Mike Harris		(606) 678-4315
		FAX	(606) 678-2050
ROBERTSON County Jail	P.O. Box 233 Mt. Olivet, KY 41064		
Judge/Executive:	Billy "Hammer" Allison		(606) 724-5615
		FAX	(606) 724-5022
Jailer:	Eddie W. Jacobs		(606) 724-5685
ROCKCASTLE County Jail	205 East Main Street #12 Mt. Vernon, KY 40456		
Judge/Executive:	Buzz Carloftis		(606) 256-2856
		FAX	(606) 256-3252
Jailer:	James E. Miller		(606) 256-2178
		FAX	(606) 256-4569
ROWAN COUNTY Detention Center	121 Lee Avenue Morehead, KY 40351		
Judge/Executive:	Jim Nickel		(606) 784-5151
		FAX	(606) 784-2923
Jailer:	Don Hall		(606) 784-8457
		FAX	(606) 784-2161

RUSSELL County Jail	23 Lewis Alley Jamestown, KY 42629		
Judge/Executive:	Mickey Garner		(270) 343-2112
		FAX	(270) 343-2134
Jailer:	Darrell McQueary		(270) 343-2523
		FAX	(270) 343-1462
SCOTT COUNTY Detention Center	130 North Court Street Georgetown, KY 40324		
Judge/Executive:	George Lusby		(502) 863-0349
		FAX	(502) 863-7852
Jailer:	Larry Covington		(502) 863-7880
		FAX	(502) 867-3727
SHELBY COUNTY Detention Center	1000 Detention Road Shelbyville, KY 40065		
Judge/Executive:	Rob Rothenburger		(502) 633-1220
		FAX	(502) 633-7623
Jailer:	Bobby Waits		(502) 633-2343
		FAX	(502) 647-1457
SIMPSON County Jail	217 East Kentucky Avenue - P.O. Box 411 Franklin, KY 42135		
Judge/Executive:	Jim Henderson		(270) 586-7184
		FAX	(270) 598-8914
Jailer:	Robert "Bob" Huber		(270) 586-5351
		FAX	(270) 586-1943
SPENCER County Jail	P.O. Box 6 Taylorsville, KY 40071		
Judge/Executive:	David Jenkins		(502) 477-8127
		FAX	(502) 477-3206
Jailer:	David Houghlin		(502) 477-8023
TAYLOR County Jail	203 Court Street Campbellsville, KY 42718		
Judge/Executive:	Eddie Rogers		(270) 465-7729
		FAX	(270) 789-3675
Jailer:	Rick Benningfield		(270) 789-1909

THREE FORKS REG DETENTION CENTER	2475 Center Street Beattyville, KY 41311		
Board of Directors:	Richard Adams, Chairman		(606) 593-6202
Jail Administrator:	Vada Wilson, Jail Administrator		(606) 464-2598
		FAX	(606) 464-3791
TODD County Jail	P.O. Box 808 Elkton, KY 42220		
Judge/Executive:	Arthur W. Green		(270) 265-2451
		FAX	(270) 265-2122
Jailer:	Greg Allen		(270) 265-2453
		FAX	(270) 265-0809
TRIGG County Jail	P.O. Box 379 Cadiz, KY 42211		
Judge/Executive:	Stanley H. Humphries		(270) 522-8459
		FAX	(270) 522-6015
Jailer:	Glen Cunningham		(270) 522-8422
		FAX	(270) 522-8422
TRIMBLE County Jail	Main Street, Courthouse Bedford, KY 40006		
Judge/Executive:	Randy K. Stevens		(502) 255-7196
		FAX	(502) 255-4618
Jailer:	Bobby Temple		(502) 255-7932
UNION County Jail	120 South Court Street Morganfield, KY 42437		
Judge/Executive:	Jody Jenkins		(270) 389-1081
		FAX	(270) 389-0406
Jailer:	James "Marty" Girten		(270) 389-1581
		FAX	(270) 389-1003
WARREN COUNTY Regional Jail	920 Kentucky Street Bowling Green, KY 42101		
Judge/Executive:	Mike Buchanon		(270) 843-4146
		FAX	(270) 781-2777
Jailer:	Jackie Strode		(270) 843-4606
		FAX	(270) 843-5317

WASHINGTON County Jail	P.O. Box 137 Springfield, KY 40069		
Judge/Executive:	John A. Settles		(606) 336-3636
		FAX	(606) 336-5407
Jailer:	Steve Hardin		(606) 336-3096
WAYNE County Jail	535 East Hwy 90 By-Pass Monticello, KY 42633		
Judge/Executive:	Gregory "Greg" Rankins		(606) 348-4241
		FAX	(606) 348-8303
Jailer:	Ray C. Upchurch		(606) 348-6781
		FAX	(606) 348-0892
WEBSTER COUNTY Detention Center	300 Stegal Street - P.O. Box 300 Dixon, KY 42409		
Judge/Executive:	James Townsend		(270) 639-5042
		FAX	(270) 639-7009
Jailer:	Terry Elder		(270) 639-7032
		FAX	(270) 639-7033
WHITLEY County Jail	P.O. Box 179 Williamsburg, KY 40769		
Judge/Executive:	Pat White, Jr.		(606) 549-6004
		FAX	(606) 549-6095
Jailer:	Ken Mobley		(606) 549-6013
		FAX	(606) 549-6031
WOLFE County Jail	P.O. Box 236 Campton, KY 41301		
Judge/Executive:	Raymond Hurst		(606) 668-3040
		FAX	(606) 668-3367
Jailer:	Dennis Brooks		(606) 668-6757
WOODFORD COUNTY Detention Center	204 Beasley Drive Versailles, KY 40383		
Judge/Executive:	John "Bear" Coyle		(859) 873-4139
		FAX	(859) 873-0196
Jailer:	Gary A. Gilkison		(859) 873-3196
		FAX	(859) 873-1014

Reference Information

Name	Address #1	Address #2	City	State	Zip
Transitions, Inc., Ashland House	465 29th Street		Ashland	KY	41101
Dismas Charities, Lexington	909 Georgetown Street		Lexington	KY	40511
St. Andrew's House	866 South Broadway		Lexington	KY	40504
Dismas Charities, Dierson Center	1218 West Oak Street		Louisville	KY	40210
Salvation Army, Lexington	736 West Main Street		Lexington	KY	40508-2096
Dismas Charities, Louisville	124 West Oak Street		Louisville	KY	40203
Dismas Charities, Owensboro	615 Carton Drive		Owensboro	KY	42303
Dismas Charities, Portland	1501 Lytle Street		Louisville	KY	40203
Dismas Charities, St. Ann's	1515 Algonquin Parkway		Louisville	KY	40210
Dismas Charities, St. Patrick's	1301 West Mark Street		Louisville	KY	40203
Transitions, Inc., Droege House	925 Fifth Avenue		Dayton	KY	41074
Paducah Community Service Center	621 South Seventh Street	PO Box 2541	Paducah	KY	42002-2541
Transitions, Inc., Two Rivers	423 Greenup Street		Covington	KY	41011
Transitions, Inc., WRAP House	1629 Madison Ave.		Covington	KY	41011-3317
Transitions, Inc., York House	601 York Street		Newport	KY	41071
Chrysalis House	120 Chrysalis Court		Lexington	KY	40508
Renaissance House	1436 Shelby Street		Louisville	KY	40202
VOA Halfway Back Program	1436 South Shelby Street		Louisville	KY	40217
Hope Center	1524 Versailles Road	PO Box 6	Lexington	KY	40588
WARM	56 North McKinley Street		Henderson	KY	42420
West Care	10057 Elkhorn Creek Road		Ashcamp	KY	41512

CorrectCare
INTEGRATED HEALTH

Quick Reference Guide

Telephone 859-225-7999 or 877-292-7999
Fax 877-229-9009 or 859-226-9099

Address where claims are submitted:

Paper Claims
CorrectCare Integrated Health
PO Box 411575
St. Louis, MO 63141-9104

Electronic Claims
EDI vendor # 90001
EDI Clearinghouse – Web MD - Healthlink

Group 1083 - State inmates housed in state facilities
Effective 10/15/03
Network - Bluegrass Family Health 5/30/06 – 12/31/07
Healthlink 1/1/08 - current

Dates of service prior to 5/30/06 were processed by the previous administrator; claims prior to this date will need to be checked on the paid claims report.

All services are paid by the Department of Corrections; these claims are processed using plan type 12.

Authorization is required for all services provided except for the exceptions listed in the processing guidelines for 1083.

Group 999 - State inmates housed in county jails and detention centers
Effective 10/15/03

Network - Bluegrass Family Health 5/30/06 – 12/31/07
Healthlink 1/1/08 - current

Dates of service prior to 5/30/06 were processed by the previous administrator; claims prior to this date will need to be checked on the paid claims report.

If the service is an Inpatient Stay or Outpatient with anesthesia the claim will be paid by the Department of Corrections. An authorization is required for these services to be paid. These claims are processed using override plan of 5.

All other services will be paid by the jail or detention center where the inmate is being housed; the claims will be re-priced and returned to the detention center to pay. These claims will have a plan of 4 for re-price.

Quick Reference Guide

Group 191 - County inmates housed in county jails and detention centers.
Effective 7.1.07

Network - Bluegrass Family Health 7/1/07 – 12/31/07
Healthlink 1/1/08 - current

All services are paid by the jail or detention center where the inmate is being housed unless the inmate is HB191 catastrophic then they are paid by the department of corrections.

If the service is an Inpatient Stay or Outpatient with anesthesia an authorization is required prior to doing the re-price, these claims will have a plan of 9.

If the inmate is HB191 catastrophic the eligibility record will be setup to indicate they are Catastrophic. The remark code will list Catastrophic HB-191 and the special remarks will show the institution where they are housed. The claims will be processed and paid with override plan of 7.

There is a spreadsheet listing the catastrophic inmates on the P drive under the claims folder. This is updated as we are notified by central office that a county inmate is Catastrophic.

Group 1100, 1200 & 1300 - CCA private institutions
Effective5/15/05

Network - CHA ASO 5/15/05 – 5/29/06
Bluegrass Family Health 5/30/06– 12/31/07
Healthlink 1/1/08 - current

Group 1300 used the CHA Preferred network for 2/1/07 – 12/31/07.

All services are paid by Corrections Corporation of America; these claims are processed with plan of 12.

Dates of service prior to 5/30/06 were processed by the previous administrator; claims prior to this date will need to be checked on the paid claims report.

Authorization is required for all services provided.

Group 1300 used the CHA Preferred network for 2/1/07 – 12/31/07.

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INTEGRATED HEALTH

GROUP PLAN	GROUP NAME	ADDITIONAL INFORMATION	NETWORK
18	12 Calloway County Detention Center-Group 999 for state, 191 for county		
19	12 Campbell County Detention Center-Group 999 for state, 191 for county	No longer processing for group	
59	12 Kenton County Detention Center	No longer process for group effective 2/1/07	
120	12 Woodford County Detention Center		Healthspan
1083	12 Kentucky Department of Corrections	No longer process for group	Bluegrass Family Health
999	4 OR 5 DOC-State Inmates housed in County Jail	Location 102-EKCC uses the CHA Network thru 12/31/07	BFH-until 12/31/07-Healthlink effective 1/1/08
1100	12 Correction Corporation of America Lee Adjustment Center	Re-price unless Inpatient or Outpatient with Anesthesia	BFH-until 12/31/07-Healthlink effective 1/1/08
1200	12 Correction Corporation of America Otter Creek Correctional Center	CCAMAC	BFH-until 12/31/07-Healthlink effective 1/1/08
1300	12 Correction Corporation of America Otter Creek Correctional Center	CCACOCCC	CHA Preferred Network until 12/31/07-Healthlink 1/1/08
1400	12 Prison Healthcare Services Little Sandy Correctional Complex	Effective 7/1/07 claims are processed under 1083-Loc 215	CHA Preferred Network until 12/31/07-Healthlink effective 1/1/08
191	9 County Inmates housed in County Jail	Reprice claims only	BFH-until 12/31/07-Healthlink effective 1/1/08
191	7 Catastrophic	Use override plan 7 to pay claims on Catastrophic list	BFH-until 12/31/07-Healthlink effective 1/1/08

PLAN	PLAN DESCRIPTION
3	Ohio Department of Correction Reprice
4	State Inmates in County Jails (Re-price claims only)
5	State Inmates in County Jails (Inpatient and Outpatient w/Anesthesia
6	Used for Contract Inmate No Check Claims
7	HB 191 Catastrophic (DOC responsible to pay these claims)
9	HB 191 County Inmates in Jails (Re-price claims only) All Services
12	State inmate plan

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INTEGRATED HEALTH

Quick Reference Guide

Group 1400 - PHS Little Sandy Correctional
Effective 5/15/05

Network
CHA ASO 5/15/05– 5/29/06
Bluegrass Family Health 5/30/07– 1/31/07
CHA Preferred 2/1/07 – 12/31/07
Healthlink 1/1/08 - current

All services are paid by Private Healthcare Systems with dates of service prior to 7/1/07.

Dates of service 5/30/06 were processed by previous administrator claims prior to this date will need be checked on the paid claims report.

Claims with dates of service 7/1/07 and after will be processed under group 1083 location 215.

Authorization is required for all services provided.

Terminated Groups

The groups listed below have terminated, prior to the termination date all claims were processed and paid under these groups. Claims after the termination date are not processed under Group 999 for State inmates and Group 191 for County inmates.

Group 18	Calloway County Detention Center	Terminated 8/1/07
Group 19	Campbell County Detention Center	Terminated 2/1/07
Group 59	Kenton County Detention Center	Terminated 6/30/08
Group 120	Woodford County Detention Center	Terminated 2/1/08

All services processed under the above groups required authorization.

Claims processed with plan of 12.

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1 Enter Claim number in Claim Adjudication
2 Search for Image in image lookup screen by SSN, Last name, or inmate number.
3 Check attending physician in block 31 and make sure physician selected in WLT provider section.
4 Also verify Inmate name, date of service and billed amount from image match claim in manual adjudication.
5 Access provider box in provider section in manual adjudication.
6 Enter provider tax ID number in provider box, tab down to name like and enter provider last name.
7 Select anywhere and list, providers with that name will pull up, select the provider on image, then maintenance.
8 Click billing address tab and make sure it matches the billing address tab in provider maintence.
9 Make sure Send checks to billing address is checked.
10 Check for authorization in DOC by entering ID, Name or inmate number.
11 Go to authorization tab and find appropriate authorization.
12 Enter Authorization number in precert field in manual adjudication.
13 Access employee tab in manual adjudication.
14 Select the Eligibility tab, make sure eligibility period and location match the information entered on auth..
15 If eligibility period and location are added, select check at bottom of screen to save changes.
16 Select Save at bottom of screen to continue processing claim.
17 Select Process Claim to process claim.
18 Verify that claim has PPO 1 for Bluegrass Family Health in line item detail at bottom of screen.
19 Select Complete Processing to complete claim.

The following 1083 locations use the CHA Preferred Network until 12/31/07-Healthlink effective 1/1/08
EKCC-Location 102-Dates of service 2/1/07 and after, dates of service prior use the Bluegrass Family Health N/W.
LSCC-Location 215-Dates of service 7/1/07 and after, dates of service prior are processed under group 1400.

**	If claim is to be denied for additional information change coverage code to NCOV and post on each line & add appropriate worksheet message on each line of claim.
**	If claim is to be denied for duplicate change coverage code to DUP and post on each line, add appropriate worksheet message on each line.
**	Claims with date of service 5/19/07 and prior need to be checked on Paid Claim report from Commonwealth.
**	If claim non par with Bluegrass Family Health, print claim add claim number and put free form comment, wrap, date initials.

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HOSPITAL	JAIL	DISCOUNT	SETUP
Pineville Community Hospital	Bell County Jail	30	6/12/2008
Fort Logan Hospital	Lincoln County Jail	30	7/16/2008
Orthotic & Prostetic Associates		105% Medicaid	7/1/2008
The Medical Center Bowling Green	ALL JAILS/HOSP & PHYSICIAN	20% discount	9/1/2008
The Medical Center of Scottsville	ALL JAILS/HOSP & PHYSICIAN	15% discount	9/1/2008
The Medical Center of Franklin	ALL JAILS/HOSP & PHYSICIAN	15% discount	9/1/2008

Invoiced Providers

1. Patricia Birchfield, ARNP
2. Family Health Network Lease Agreement
3. Bowersox Vision Center
4. Gil Brewsaugh
5. Pro Staff
6. CB Imaging
7. CCA Contract LAC
8. CCA Contract OCCC
9. CCA Contract MAC
10. Clear Vision Eye Center (Dr. Todd McGeorge ODJ)
11. Eye Care Associates of Kentucky (J.P. Lyles, OD)
12. Eye Care Associates of Kentucky (David Jacobs, OD)
13. Charles French OD
14. Fresenius Medical Care
15. Fulton County Contract
16. William Greeman Md
17. HealthLink
18. Healthspan
19. Theresa Hobson (PT Contract)
20. Marshal Jenkins
21. Kentucky Nephrology Research Trust
22. Phillip LeFeuvre Md
23. Jason McCloud
24. McKesson Contract
25. Medical Society Professional Service
26. Larry R Miller OD
27. Smith Optometry
28. Theracare Allicance
29. University Medical Associates (Dr. Anna Huang)

WRAP Networks

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MULTIPLAN PPO-Effective 8/15/08

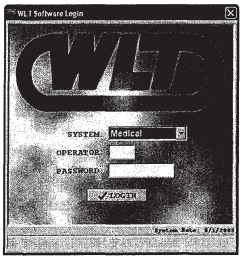
1. Image lookup will display Multiplan in the PPO field and the notes field.
2. Enter PPO override of 20 on the claim when the discount is Multiplan.
3. Worksheet message should be changed to #80 on each line, "Multiplan Discount Agreement".
4. Free form comment will display Paid per Multiplan contracted rate.
5. It is very important that the Multiplan claims have the correct PPO override when processing claims.

WLT Claims

Introduction to System

Login

To begin working on the WLT system, you must enter your assigned operator number and password. Each operator has a unique operator number and password so that transactions can be traced to the operators who made them. Therefore, each operator's password should remain confidential.



Logout

You must close all WLT programs before logging out. Should you forget, the system will remind you.

To log out of the system, simply click on LOGOUT. You should log out anytime you are away from your terminal. This prevents unauthorized access to the system, and requires other operators to log in using their own operator number and password in order to use your workstation.

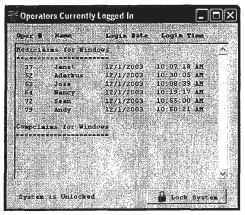
As an additional security feature, when no WLT programs have been running for a defined period of time, the operator will automatically be logged out of the system. This feature can be defined in System Control - System Configuration and Codes.

Menu Bar

The menu bar is divided into seven categories: Processing, Maintenance, Reports/Inquiry, Premium Billing/Agent Commissions, Updates, System Control, and Custom. Each category has related subcategories which will be explained in more detail. Simply click on the menu name to display a listing of the available options or press the Alt key and the shortcut letter (e.g. Alt-P for Processing).

Operators Currently Logged In

The binoculars icon is the **Operator Currently Logged In** button on the WLT tool bar. This will display who is currently logged into the system(s) for WLT. This also allows a supervisor to lock or unlock the system.

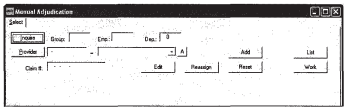


Claims Processing

Manual Adjudication

This option allows you to manually process claims submitted on a HCFA1500, UB-04, or ADA claim form. Claims are manually added, processed and adjudicated during this function. You also have the ability to override the claim during this process.

This screen also allows you to access provider, employee and dependent inquiry functions.



To add a claim, enter the following information.

Note: If unsure of the claimant or provider, you can use the inquiry functions described later in this section.

Group - Enter the employee's group number. If you do not know the group number, click the **Inquire** button to access the inquiry function.

Emp. - Enter the employee number. If you do not know the employee number, click the **Inquire** button to access the inquiry function.

Dep. - If the claim is for a dependent of the employee, enter the dependent number. If an invalid dependent number is entered, the system prompts **CLAIMANT NOT FOUND**; click **OK** to continue. If you do not know the dependent number, click the **Inquire** button to access the inquiry function.

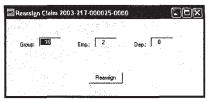
Provider - Enter the provider's tax identification number. After entering a provider number and tabbing out of the field, a list will be automatically displayed showing the suffix numbers and names of all the providers having this tax identification number. Click the **A** button to display the list in alphabetic order; click the **#** button to return the list to numeric order. If you are unsure of the provider's tax identification number, click the **Provider** button to access the inquiry function.

Note: When the claimant and provider have been identified, their demographic information will be displayed on the screen for visual confirmation.

When the claimant and provider have been identified, click **Add** on the initial Claim Entry screen to open the **Claim Info** tab.

To view or change a previously entered claim, enter the claim number in the **Claim #** field and click **Edit**. If unsure of the claim number, you can identify the claimant and click **List** to bring up a listing of all claims for the claimant.

You can also reassign an un-adjudicated claim to a different group and employee/dependent. To reassign a claim, enter the claim number and click **Reassign** to bring up the following screen.



Enter the number of the group, employee, and dependent to which you want to reassign the claim and click **Reassign**. The system will acknowledge that the claim has been reassigned.

To reset an adjudicated, unpaid claim to a 'just entered' status, enter the claim number and click the **Reset** button.

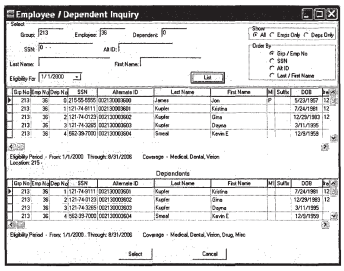
Click the **Work** button to access the Work Flow feature; a listing of open claims that have been assigned to you will be listed by default.

Inquiry Functions

Employee/Dependent Inquiry

The Inquire button accesses the Employee/Dependent Inquiry screen. This screen displays eligibility and coverage information, as well as location, demographic and some override information for employees and dependents. You can search by **Group**, **Employee**, **Dependent**, **SSN**, **Alt ID**, **Last Name** and **First Name**. You can also search for eligibility information as of a specified date. Once you have entered your search criteria, click the **List** button to list the results of your search. Within each grid, the selected claimant's eligibility period and coverage will be displayed.

Note: When this program is opened, your cursor is automatically directed to the initial field specified in System Configuration & Codes (Emp/Dep Inquire Initial Field).



Show

Select the type of information to be displayed: **All** to show both employees and dependents, **Emps Only** to list only employees, or **Deps Only** to list only dependents.

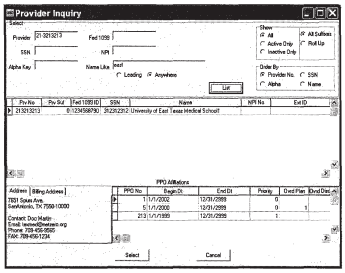
Order By

Select the order in which you would like your search results displayed. You can order your search results by **Grp/Emp No**, **SSN**, **Alt ID**, or **Last/First Name**.

Once you have found the patient you are looking for, either double click on it in the grid or click the **Select** button to automatically populate the group, employee, and dependent numbers on the initial Claim Entry screen.

Provider Inquiry

The **Provider** button accesses the Provider Inquiry screen that displays demographic information and PPO affiliations. You can search for providers using their **Provider** number, **Fed 1099** number, **SSN, NPI, Alpha Key**, or **Name**. The **Name Like** function allows you to search for providers by entering a partial name. Name searching with the **Leading** option looks at the first letters of a providers name to attempt to match your search criteria. When you search with the **Anywhere** option the search looks anywhere in the provider name for the search criteria you have entered. Once you have entered your search criteria click the **List** button to display the results.



Show

Select the type of information to be displayed: **All, Active Only**, or **Inactive Only**. Additionally, you can select **All Suffixes** to display all provider number suffixes related to a provider number or **Roll Up** to view only the primary provider (suffix zero) information.

Order

Select the order in which you would like the search results displayed: **Provider No., Alpha, SSN**, or **Name**.

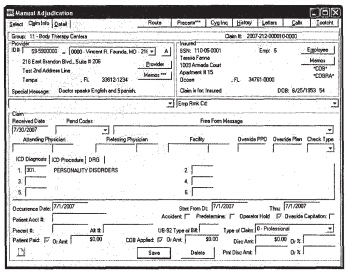
For the indicated provider in the grid, service and billing addresses are displayed at the bottom of the screen, as well as all PPO affiliations. Once you have selected the correct provider, either double click on it in the grid, or click the **Select** button to automatically populate the provider number and suffix fields on the initial Claim Entry screen.

Notes:

Claim Info

After identifying the patient and provider on the initial entry screen and then clicking the **Add** button, you will be taken to the **Claim Info** tab. At the top of the screen, the **Route** button allows you to route the claim to another processor through the Work Flow process. The **Precerts** button will access Precertification Maintenance for the claimant, the **Cvg Inq** button will access Employee/Dependent Coverage Inquiry, the **History** button will access Claim Inquiry for the claimant, the **Letters** button will access the view/edit portion of Letter Entry listing all letters for the claimant, the **Calls** button will access the **Call Tracking** function, and the **Toothchrt** button will access the **Tooth Chart**.

In the **Provider** area, the provider ID and suffix can be changed if necessary. Click **Provider** to access the Provider Inquiry function for the entered provider. Click **Memos** to access the Provider Memos for the entered provider; when memos exist for the provider, asterisks will appear on the **Memos** button.



If any generic special messages have been defined for the group, they will be displayed in the area labeled **Group Special Messages**.

The **Insured** area displays information about the insured and the patient. Click **Employee** to access Employee/Dependent Maintenance for the insured. Click **Memos** to access the memos function for the patient; when memos exist for the patient, asterisks will appear on the **Memos** button. For employees and dependents who have the COB flag set in Employee Maintenance, a *COB* notation will appear in this area. For employees who are flagged for COBRA, a *COBRA* notation will appear. Any special remarks or remark codes defined for the patient will be displayed in a drop down list below the **Insured** area.

Received Date - Enter the received date of the claim.

Pend Code - Enter the pend code if the claim should be prevented from going through adjudication. You may select from the drop down list of pend codes that had been previously established in System Control, System Configuration & Codes.

Free Form Message - A free-form message can be typed in, or a message can be selected from the drop down list of previously defined messages. System-wide free form messages can be defined in System Control, System Configuration & Codes. This free form message will print on the EOB portion of the check for this claim.

Attending Physician - Enter the federal tax identification number of the attending physician. If the bill is from a hospital or clinic, the attending physician is the physician involved with the case. Leave the field blank if there is no attending physician.

Referring Physician - Enter the federal tax identification number of the referring physician. Leave the field blank if there is no referring physician.

Facility Number - Enter the facility identification number of the facility where the services were rendered. Leave the field blank if there is no facility number.

Override PPO - If this claim should be adjudicated based on the parameters of a specified PPO instead of the parameters of the plan, enter the number of the PPO. To force the claim to pay out-of-network even if there is a PPO in place, enter -1 (negative one).

Note: When PPOs are attached to the group and the provider of service is participating, the applicable PPO is assigned automatically to the claim. This field is used to force a manual override of any assignment that would have automatically taken place.

Override Plan - If this claim should be adjudicated based on the parameters of a specified plan instead of the current plan, enter the number of the plan.

Note: When plans are attached to the group, or assigned to the claimant as an override, the applicable plan is assigned automatically to the claim. This field is used to force a manual override of any assignment that would have automatically taken place.

The **Check Type** field allows you to override the check type. If none of the following options are applicable to the claim, leave this field blank.

No Pay - Creates an EOB for a no-check claim
Prf Ctsy - Consider the claim to be a professional courtesy claim, regardless of whether or not this provider is indicated in Group Maintenance as a Professional Courtesy Provider.
Pay First - Print this claim first in the check run, regardless of the check sequence options defined for this group.
2 Party - A two party check payment will issue a check payable to both the employee and provider, even if the group is not flagged for 'Two Party Check Payment' in Fund Maintenance.

ICD Diagnosis - You may enter up to six diagnoses per claim by entering the ICD code for each. These are verified against the diagnosis codes established in Diagnosis Code Maintenance. If an invalid code is entered, you will be prompted.

ICD Procedure - You may enter up to four ICD Procedures per claim. These are verified against the ICD procedures established in ICD Procedure Code Maintenance. If an invalid code is entered, you will be prompted.

DRG - Enter the DRG code applicable to this claim in order to process according to the DRG limit defined in the plan.

Occurrence Date - Enter the date of the reported incident.

Statement From and **Thru** dates - The Statement From and Through dates will default to the occurrence date. If this is not correct, change the dates to include the range of the billing period. All dates of service for the claim should be included in this range.

Patient Acct. # - Enter the patient account number as it appears on the claim form. This will print on all checks that are issued and will assist the provider in crediting the proper patient's account.

Accident - This option, when selected, will adjudicate the claim under the supplemental accident provisions of the plan. Leave this field blank when this parameter is not used. The Occurrence Date should be the date of the accident. Separate accidents are tracked by the system based on service dates and diagnosis codes within a 90-day time frame.

Predetermination - Select this option if you wish to process the claim for predetermination of benefits. Predetermination claims will be edited and partially adjudicated, but accumulators will not be updated and checks cannot be produced until this flag has been removed. To print a predetermination EOB, use the Reports/Inquiry, Miscellaneous, Predetermination Letters option.

Note: This option is also useful when you are entering a claim solely to test a new plan benefit and you want to ensure that it generate a check.

Operator Hold - Select this option to put a claim on hold after adjudication. The claim can be edited, adjudicated, and put through the daily update. It will appear on the supervisory audit report as a held claim. The claim will be stopped from going through a check run until it is released in Edited Claims Maintenance.

Override Capitation - Select this option if the plan is capitated and this claim should not apply to capitation processing. Otherwise, leave this field blank.

Precert # - If editing for precertifications, enter the precertification number for the claim.

Alt # - If you have a precertification number assigned by an external source, enter it here for informational purposes.

UB-92 Type of Bill - Enter the number found in box 4 on the hospital claim form. This is required if doing electronic repricing of Institutional claims.

Type of Claim - Indicate the type of claim: **Professional, Institutional**, or **Dental**. This is required if doing electronic repricing of 837 claims. If a type of claim is not selected here, the claim will be considered to be a professional claim by default.

Patient Paid Or Amt. - If the patient has paid the entire charge at the point of service, click the **Patient Paid** box. Any plan responsibility in excess of the employee's responsibility will be reimbursed back to the employee. If the patient has paid only a portion of the charges to the provider, enter the amount that has been paid in the **Amt** field, not including copayment amounts. If payment of the claim is assigned to the provider, payment will only be issued to the provider for the amount due. Any amount of payment that exceeds the balance due will be issued to the employee on a separate check.

COB Applied - Select this option if the primary carrier processed the claim, but did not issue a payment. (For example, covered charges were applied towards the claimant's deductible.) Do not enter a dollar amount in the **COB Amt** field. This will allow the claim to be processed as COB without triggering the "Insured has COB" edit.

Note: You need to select this option if you are using COB Savings Code '3' in Group Maintenance.

COB Amt - If the claimant has a primary insurance carrier (coordination of benefits), enter the amount of the primary carrier's payment. If COB Payment Code is 3 in Group Maintenance, this field will be disabled.

Note: In adjudicating a COB type claim, the system first calculates the eligible charge and determines the benefits payable in the absence of another carrier. If the claim applied an amount to the claimant's deductible, or satisfied the claimant's deductible, the entry automatically applies the deductible. (Even though the employee did not pay any portion of the claim.) Based on the COB amount and the calculated maximum benefit payment, the system determines the distribution between the plan and the employee while never exceeding 100% of the charge amount. When the amount of the COB obligation is greater than the maximum benefit payable, and the plan allows for the accumulation of COB savings dollars (as defined in Group Maintenance), the system withdraws these saved COB dollars to pay deductible and co-pay amounts on future claims. When the system uses these COB dollars, it assigns the explanation code, COB Savings Applied, in the Explanation Code field.

Discount Amt or % - If the claim has a global discount amount to be applied to the entire claim, enter it in the **Disc Amt** field. This amount will be proportionately applied to each claim line, adding to any claim line discounts that are entered for each line. If the claim has a global discount percentage to be applied to the entire claim, enter it in the % field.

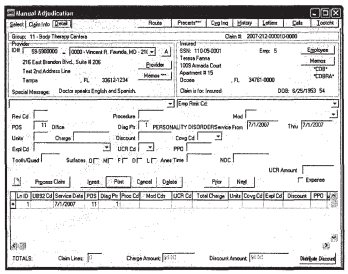
Pmt Disc Amt or % - If the claim has a global discount amount to be applied to the payment, enter it in the **Pmt Disc Amt** field. This amount will be proportionately applied to the payment on each claim line. If the claim has a global discount percentage to be applied to the payment, enter it in the % field.

On the bottom left corner of the screen, click the button to view or add internal claim notes.

After you have entered the claim information, click **Save**. The Detail screen will be displayed.

Claim Detail

Claim line information is entered in the center of the screen. As each line is posted, it will be displayed at the bottom of the screen. Use the toolbar to **Insert**, **Post**, or **Delete** claim lines. If a claim line is deleted, the **Ln ID** (claim line number) will not be used again.



Rev Cd - If the claim is for hospital services, enter the Revenue Code. If the claim is for professional services, leave this field blank.

Procedure - Enter the procedure code for the service as indicated on the claim form. If an invalid code is entered (verified against the procedure codes established in Procedure Code Maintenance), you will be prompted.

Mod - Enter the modifier code for the service as indicated on the claim form. If an invalid code is entered (verified against the modifier codes established in System Configuration & Codes), you will be prompted.

POS - Enter the place of service code for the service as indicated on the claim form. If an invalid code is entered (verified against the place of service codes established in System Configuration & Codes), you will be prompted.

Diag Ptr - Enter the indicator number (i.e., 1, 2, 3, 4, 5, or 6) for the diagnosis code(s) entered on the previous screen.

Service From/Thru - Enter the date of service for the charge line. These fields are automatically filled in with the date in the **Stmt From Dt** field on the **Claim Info** screen, but can be changed.

Units - Enter the number of units or services rendered for the charge line. If this field is left blank, the system assumes '1' (one).

Charge - Enter the total dollar amount of the charge for the code.

Discount - Enter the discount amount for this procedure. To apply a discount in this field, the **Global Discount Amount** field on the previous screen must be left blank. If a claim line discount is entered and a Global Discount is used, they will be added together.

Covg Cd - Select the coverage code for the entered procedure. This is filled in automatically based on the Coverage Assignment settings for the diagnosis, place of service, provider type, procedure and/or modifier codes entered, but it can be changed as needed.

Note: The coverage code assigned to the claim line is based on priority. 1) If the diagnosis code on the first screen has an override coverage code (defined in Diagnosis Code Maintenance), this will be the coverage code used, overriding all other coverage code assignments. 2) If a revenue code is used on the detail line, the coverage code assigned to the revenue code will be used. 3) If the diagnosis code doesn't have an override coverage code

and a revenue code is not being used, the most appropriate coverage code assignment defined in System Control, Coverage Assignment will be used.

Expl Cd - Select the explanation code applicable for this charge line. Even if a code is not selected here, the system will still assign up to three messages based on predefined parameters.

UCR Cd - Enter the type of UCR database to apply to the procedure:

- **M** - The charge is medical/surgical or HCPCS and is to be checked against the medical UCR file.
- **D** - The charge is dental and is to be checked against the dental UCR file.
- **A** - The charge is anesthesia and is to be checked against the anesthesia UCR file
- **O** - The charge is outpatient and is to be checked against the outpatient UCR file.
- **B** - The charge is to be checked against the RBRVS UCR file.
- **Blank** - Instructs the system not to edit for a UCR amount.

PPO - You can enter a claim line level PPO override. The PPO must be attached to the group before it can be used in claims processing.

Tooth/Quad - Enter the tooth designation (alpha or numeric), or the quadrant. Letters **A** through **T** are used for primary teeth (child), and numbers **1** through **32** are used for permanent teeth (adult). You can also specify the quadrant by entering **Q1**, **Q2**, **Q3**, or **Q4**.

Surfaces - Indicate the applicable tooth surface(s):

- O - Occlusal
- I - Incisal
- M - Mesial
- F - Facial
- B - Buccal
- D - Distal
- L - Lingual

Time Units - If the selected **UCR Cd** is 'A' for anesthesia, enter the hours and minutes (as HH:MM) for the procedure.

NDC Number - For drug claims, enter the NDC number (if known).

Expense - Select this option to process this claim as an expense claim. If this option is selected, go to the **Covg Code** field and select the correct EX__ code. (EX02, for example).

Distribute Discount - Click this button to display how the global dollar discount will be broken down prior to processing the claim. The amounts will add to any existing line item discounts and then erase the global dollar discount amount from the prior screen. If this option is not selected, the adjudication process will still break it down without displaying it first. All other discount options (global percentage discount, payment discount amount or percentage) will not display with this button, but will be handled by the claim adjudication program.

On the bottom left corner of the screen, click the button to view or add internal claim line notes.

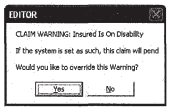
Enter the claim information and click **Post** to save the claim line or **Cancel** to clear the line. Click **Insert** to add a new charge line. To remove an existing claim line, select the applicable line and click **Delete**. To move up and down through the claim lines use the **Prior** and **Next** buttons or use the scroll bar and click on the selected line item. Click the **Process Claim** button to edit and adjudicate this claim.

Note: The Ln ID column number does not reset if a claim line has been deleted.

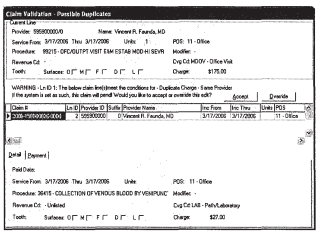
Notes:

Claim Editing

The edits, whether they are Errors or Warnings, will pop up in a message box. If the processor has the security to override the edit they will be prompted with a **Yes/No** option to override the system for the edit. Select **Yes** to override the edit and the system will continue with the editing and adjudication process. Select **No** to accept the edit. However, if the processor does not have the security to override, then only the edit message is displayed and the user is prompted to **OK** the edit to accept it. If the edit is defined as an Error in Group Edit Specifications, and Errors are flagged to pend automatically, the claim will be pended and no further edits will be displayed. Edits defined as Errors will cause the charge for the claim line to be denied unless the edit is overridden. Similarly, if the edit is defined as a Warning in Group Edit Specifications, and Warnings are flagged to pend automatically, the claim will be pended.



If the edit is for one of the duplicate claim edits, then the **Claim Validation** screen is also displayed. The **Current Line** area of this screen will display the information for the claim line that tripped the edit. Below that will display the type of edit and the users with the security to do so will be able to either **Accept** the edit as being a duplicate or **Override** the edit to continue processing. Next, claim information is displayed for those claims which triggered the duplicate edit with their detail and payment information below that.



Detail - Displays the paid date, if applicable, and claim information per claim line.

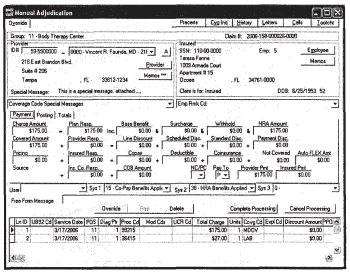
Payment - Displays a breakdown of payment information per claim line.

If the claim pends due to a pend reason assigned to the patient in Employee/Dependent Maintenance, the pend reason will be displayed on the screen.

Notes:

Claim Override

After all edits have been displayed and appropriate action has been taken, the claim will proceed to the Adjudication process. The **Payment** screen will display a breakdown of how the payment was determined, as well as the explanation codes that were assigned by Adjudication. You can click on the **Posting** tab to view how accumulators were updated, and the **Totals** tab will display field totals for all claim lines combined. This information can be manually changed by clicking the **Override** button and then making the applicable modifications. To accept the adjudication of the claim as it is displayed, click the **Complete Processing** to finalize the claim. Below the payment breakdown, the following fields are also displayed:



User - This is the explanation code selected by the processor on the claim **Detail** screen.

Sys.1, 2, 3 - System generated Explanation Codes.

Free Form Message - If a PPO message appears, you have the ability to add to the existing message (up to 40 characters). You may also enter a new free form message, or select from the drop down list of previously defined claim free form messages. This message will appear on the EOB portion of the check issued.

Override - Click on this button to set the claim in edit mode, to be able to override. You have the ability to make changes to the payment, or how it was posted to the accumulators. The **Totals** tab will be automatically updated to reflect any changes made to the payment. If you do not need to make any changes to this claim, do not select this option. Instead, select **Complete Processing**.

Note: If you override the payment of a claim, you must also manually adjust the accumulators on the Posting tab.

Delete - Click on this button to remove a claim line.

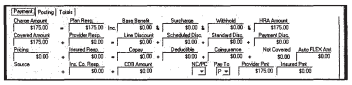
Complete Processing - When you have completed and posted your changes, click on this button to finalize the adjudication of the claim.

Cancel Processing - If the claim was not entered correctly, click on this button to bring you back to the **Claim Detail** screen to allow you to make the necessary changes.

Payment Tab

For each claim line selected, this tab will display the complete breakdown of the monies involved. Click the **Override** button to make modifications to this screen. If you make a change to the payment of a claim, you will need to manually determine whether any applicable accumulators will also need to be updated.

The Charge Amount equals the Plan Responsibility plus the Provider Responsibility plus the Insured Responsibility plus the Insurance Company Responsibility plus any COB amounts.



Plan Responsibility - Includes Base benefits, Surcharge and Withhold.

LCD - Indicate whether the Dollar Limit is on the Charge amount or the Payment amount.

C - The dollar limit is for the eligible charge calculated before deductible and coinsurance. Once the charge limit is met, the benefit will roll over to the next coverage level.
P - The dollar limit is for the eligible payment calculated after the deductible and coinsurance. This benefit will not roll over to another level.

Ann Vsts - Establishes the maximum number of visits for the coverage per year. If visits are unlimited, leave blank. If multiple coverage codes track to the same visit limit, use the annual limit, defined in Plan Info, instead.

VCD - Use this option to indicate that multiple visits/units on the same date of service are to be counted only once towards visit limits.

D - One count for all procedures (utilizing a coverage code with a VCD = D) by the same provider on a given day. To apply this feature to multiple coverage codes, each coverage code should be coded in a similar manner.
E - One count for all procedures (utilizing a coverage code with a VCD = E) on a given day, regardless of the provider. To apply this feature to multiple coverage codes, each coverage code should be coded in a similar manner.

Note: The outcome of the unit visit count is determined by how the D and E codes are entered and processed during Adjudication. For example, if an E coded claim is following a D coded claim (for a different provider), the visits would not be counted. If the D coded claim is following an E coded claim (for a different provider), the visits would count for the both. Similarly, if a claim is processed with a coverage code defined with a VCD of E, subsequent to a claim with the same incurred date and no VCD, the E coded claim will not be counted against the visit limits. However, if the order is reversed both claims will count.

Visit Per - Establishes the time-frame limitations of one visit during a selected period. If none, leave blank. For example, if the time-frame limitation is one visit every six months, enter "6" in this field and "M" in the Per Period field.

Per Period - Establishes the period limitations of one visit for the selected time-frame. If none, leave blank. For example, if the time-frame limitation is one visit every six months, enter "6" in the Visit Per field and "M" in this field.

D - Days between visits
W - Weeks between visits
Y - Years between visits
M - Months between visits

Per Den - Indicate whether the time frame limit defined in the "Visit Per" and "Per Period" fields is tooth (or quadrant) or surface specific. If the defined time frame is not tooth or surface specific, leave blank.

T - Tooth (or quadrant) specific (regardless of surface)
S - Tooth <u>and</u> surface specific

HRA Exc - If utilizing an HRA within the plan, indicate whether portions of the HRA are to be excluded from processing.

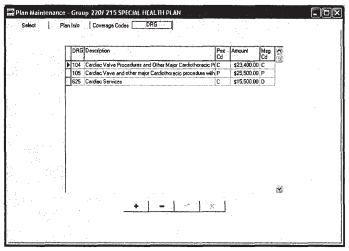
F - Not Excluded.
P - Plan responsibility is excluded.
E - Employee responsibility is excluded.
T - The coverage code is totally excluded from HRA consideration.

FSA Exc - Indicate whether the coverage code should be excluded from FSA consideration.

DRG Exc - Indicate whether the coverage code should not be applied to DRG limits.

DRG

The DRG tab can be used to define DRG limitations. Use the navigation bar at the bottom of the screen to add or delete DRG limits. DRG codes must first be entered in System Configuration & Codes.



DRG - Enter the DRG code for which you wish to establish a plan limitation.

Description - When the DRG has been entered, the description will be displayed automatically.

Pmt Cd - Indicate how to apply the amount defined in the **Amount** column.

C - Case Rate (annual limit)
P - Per Diem (daily limit)

Amount - Enter the amount limitation for the DRG.

Msg Cd - Indicate which explanation code to use when processing a claim that is applied to a DRG limit.

C - Use the explanation code coded as DRGCDC (reduced for Case Rate). For additional information about explanation codes, please refer to System Configuration & Codes.
P - Use the explanation code coded as DRGCDP (reduced for Per Diem). For additional information about explanation codes, please refer to System Configuration & Codes.
D - Use the explanation code coded as DRGCDD (reduced for DRG). For additional information about explanation codes, please refer to System Configuration & Codes.

Notes:

Claims Editor Messages

This option allows you to edit descriptions for the Claims Editor's warning messages for each of six categories: **Charge Line Edits**, **Claim/Patient Edits**, **Procedure Code Edits**, **Diagnosis Edits**, **Dental Edits**, and **Precertification Edits**. The edits are position specific and their descriptions should not be changed (edits are applied based on their numbered location in the list).

Explanation Code – When a claim line is denied due to an edit that is defined as an Error, explanation code #20 (Editor Denial) is assigned by default. Enter an override explanation code (defined in System Configuration & Codes) to be assigned instead of the system default explanation code #20.

Drug Ignore - Select this option if you want the edit bypassed when processing a claim with a drug claim type (such as batch drug).

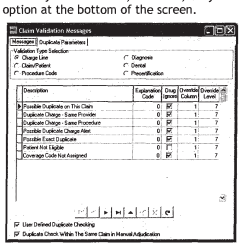
Override Column and Level - Allows you to set secondary levels of required security so that you can define which pending edits cannot be bypassed by processors using Manual Adjudication. When these are set, a processor will need these minimum security settings to override the pend. Manual Adjudication program security must be set in order for this feature to work.

User Defined Duplicate Checking - Select this option to manually customize your duplicate edit parameters for the system. If not selected, the system will use the default parameters for duplicate checking.

Duplicate Check Within The Same Claim in Manual Adjudication - Select this option if you want to edit for duplicate conditions within the same claim during Manual Adjudication. Otherwise, do not select this option if you don't care to check for duplicate conditions within the claim currently being processed. Claims that are edited through Select Claims to Process will continue to check for duplicates within themselves regardless of this option.

Charge Line Edits

Charge Line E dits compare the claim's detail line entries with each other and with those in the claimant's history. The definitions of the five duplicate edits are system defaults; however, they can be customized by selecting the **User Defined Duplicate Checking** option at the bottom of the screen.



Possible Duplicate on this Claim - Procedure, modifier, and date of service are the same.

Duplicate Charge - Same Provider - Provider, date of service, and amount are the same.

Duplicate Charge - Same Procedure - Procedure, date of service, and modifier are the same, or if the modifiers are different, the charge amounts are within 15% of each other. Modifier 80 is ignored for this edit.

Possible Duplicate Charge Alert - Provider is the same and date of service is within plus or minus seven days.

Possible Exact Duplicate - Provider number excluding provider suffixes, procedure code, modifier, date of service, and amount are the same.

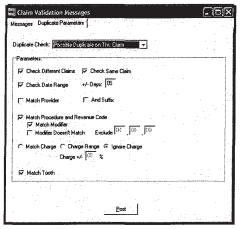
Patient Not Eligible - Incurred dates are not within the coverage period for the patient.

Coverage Code Not Assigned - No coverage code has been designated for this procedure.

Duplicate Parameters

If you have selected **User Defined Duplicate Checking** on the previous screen, the **Duplicate Parameters** screen allows you to customize the parameters for each of the five duplicate checking edits. From the **Duplicate Check** drop down list, select the edit that you wish to customize and then select the applicable parameters on the screen. As you finish defining each edit, be sure to click the **Post** button before you select the next edit from the drop down list. If you customize one duplicate edit to meet your specifications, you must define them all.

Parameters



Check Different Claims - Select this option to check all claims for possible duplicates against the claim you are editing. If not selected, it will ignore other possible duplicate claims.

Check Same Claim – Select this option to look within the claim you are currently editing for possible duplicates. If not selected, it will ignore the possible duplication within the same claim. This option works in conjunction with the "Duplicate Check within the Same Claim in Manual Adjudication" option. If you are using this option, "Duplicate Check within the Same Claim in Manual Adjudication" must be flagged.

Check Date Range - Select this option to edit for possible duplicate claims within a defined number of days (based on date of service) and then enter the tolerance level in the **+/- Days** field. If not selected, it will ignore all possible duplicate claims within a date range.

Match Provider - Select this option to edit for possible duplicate claims with the same provider of service, regardless of suffix. If not selected, it will ignore all possible duplicate claims that have the same provider.

And Suffix - Select this option to include the provider's suffix when checking for duplicate claims. A match must be made for the TIN and suffix. If not selected, it edit for all possible duplicate claims that have the same provider, regardless of suffix.

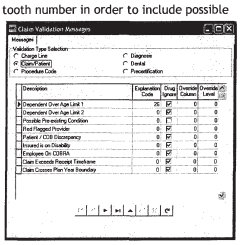
Match Procedure and Revenue Code - Select this option to require a match on the procedure code/revenue code. You may also select **Match Modifier** to require a match on the modifier code. Select **Modifier Doesn't Match** to indicate that matching on the modifier isn't necessary, with the exception of up to 3 selected modifiers. For example, you may not want to always require a match on modifiers, with the exception of 51 (multiple surgeries) which you may always want to check for.

Match Charge – Select this option to include all claims with a matching charge amount.

Charge Range - Select this option to include all claims within a percentage range of the charge amount, and then enter the percentage tolerance in the **Charge +/-** field.

Ignore Charge - Select this option to ignore the charge amount when checking for possible duplicate claims.

Match tooth – Select this option to require a match on the tooth number in order to include possible duplicate claims. If this option is not selected, it will ignore any possible duplicate claims with a tooth match.



Claim/Patient Edits

Claim/Patient Edits compare the claim with the claimant's status.

Dependent Over Age Limit 1 - Dependent is over the age defined in the Age 1 field in Group Edit Specifications.

Dependent Over Age Limit 2 - Dependent is over the age defined in the Age 2 field in Group Edit Specifications.

Possible Preexisting Condition - Claim incurred within the Preexisting Months to Check defined in Group Maintenance.

Red Flagged Provider - Provider is red flagged in Provider Maintenance.

Patient/COB Discrepancy - The patient is flagged for COB in Employee/Dependent Maintenance and a COB amount was not entered for the claim OR the patient is not flagged for COB in Employee/Dependent Maintenance and a COB amount was entered for the claim.

Insured Is on Disability - Disability is indicated in Employee/Dependent Maintenance.

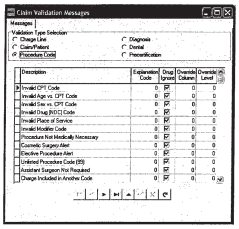
Employee on COBRA - COBRA Employee is indicated in Employee/Dependent Maintenance.

Claim Exceeds Receipt Timeframe - Charges were received after the time period selected in Group Maintenance.

Claim Crosses Plan Year Boundary - The claim incurred dates span more than one plan year.

Procedure Code Edits

Procedure Code Edits compare the claim's detail lines with the values in Procedure Code Maintenance.



Invalid CPT Code - No match as an existing CPT, ADA, or HCPCS procedure code, defined in Procedure Code Maintenenace.

Invalid Age vs. CPT Code - Age does not match the age limits defined in Procedure Code Maintenance.

Invalid Sex vs. CPT Code - Gender does not match the gender defined in Procedure Code Maintenance.

Invalid Drug (NDC) Code - Not a valid drug code per Medi-Span. If you do not subscribe to Medi-Span, this should be coded 'I' in Group Edit Specifications to ignore.

Invalid Place of Service - Place of service is not valid for the procedure.

Invalid Modifier Code - Not a valid modifier for the procedure code used.

Procedure Not Medically Necessary - Procedure code is flagged as not medically necessary in Procedure Code Maintenance.

Cosmetic Surgery Alert - Procedure code is flagged as a cosmetic procedure in Procedure Code Maintenance.

Elective Procedure Alert - Procedure code is flagged as being an elective surgery in Procedure Code Maintenance.

Unlisted Procedure Code (99) - Procedure code ends with '99', which defines it as being unlisted. A written description should be obtained to determine services rendered.

Assistant Surgeon Not Allowed - Assistant surgeon is indicated by the modifier (80, 81, or 82) and the procedure code is not flagged as assistant surgeon allowed in the Procedure Code Maintenance.

Charge Included in Another Code - Charge is unbundled and is part of another charge.

Possible Incidental Procedure - Procedure is indicated as being possibly incidental (defined on the unbundling tab in Procedure Code Maintenance).

Charge Made Within Follow-up Days - New charge made by the same provider TIN (regardless of suffix) within the follow-up time frame specified for the procedure, and the procedure is flagged to deny in follow up (defined in Procedure Code Maintenance).

Cannot Bill Within Time Frame - Based on number of services and frequency.

No Usual and Customary Amount - No UCR allowance found for this procedure.

Charge over Usual Amount - Charge exceeds the reasonable and customary allowance.

Possible Catastrophic Alert - Procedure code is flagged as catastrophic in Procedure Code Maintenance.

Possible Up-Coding Alert - Billing for a more difficult procedure.

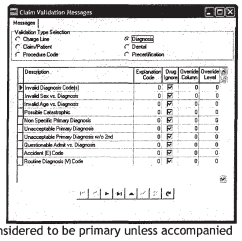
Over the Counter (OTC) Drug Alert - Drug is coded as an over-the-counter drug. If you do not subscribe to Medi-Span, this edit should be coded as 'I' in Group Edit Specifications to ignore.

50% Price Test - Amount is 50% or less than the UCR. Generally used as an indicator that there may be unbundling.

Procedure Not Valid for Date - The procedure was performed outside of the valid dates defined in Procedure Code Maintenance.

Diagnosis Edits

Diagnosis Edits compare the claim with the values in Diagnosis Code Maintenance.



Invalid Diagnosis Code(s) - Diagnosis does not match an existing code in Diagnosis Code Maintenance.

Invalid Sex vs. Diagnosis - Diagnosis is sex specific; the gender does not match.

Invalid Age vs. Diagnosis - Diagnosis is age specific; the claimant's age does not fall within the defined age range.

Possible Catastrophic - Diagnosis is coded as possible catastrophic.

Non-Specific Primary Diagnosis - Diagnosis represents a nonspecific diagnosis (edit code 'N').

Unacceptable Primary Diagnosis - Diagnosis is not considered to be primary (edit code 'U').

Unacceptable Primary Diagnosis w/o 2nd - Diagnosis is not considered to be primary unless accompanied by a secondary diagnosis (edit code '2').

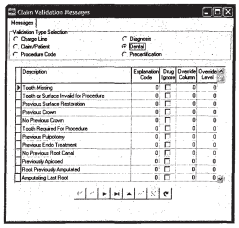
Questionable Admission vs. Diagnosis - The requirement for hospital admission is questionable for this diagnosis (edit code 'Q' and claim is inpatient).

Accident Diagnosis - Diagnosis code is accident related (external cause) (800-999 and E800-E999).

Routine Diagnosis (V Code) - Diagnosis code is routine (V code).

Dental Edits

Dental Edits compare dental procedures to the claimant's tooth chart or to the values established in Dental Procedure Code Edit Maintenance.



Tooth Missing - Tooth has been extracted.

Tooth or Surface Invalid for Procedure - The tooth or surface or root is invalid for the procedure entered.

Previous Surface Restoration - A restoration has been performed on the same surface of the same tooth prior to this restoration.

Previous Crown - A crown has existed on the same tooth prior to this.

No Previous Crown - No prior crown.

Tooth Required For Procedure - A tooth is required for this procedure if an edit record has been established in Dental Procedure Code Edit Maintenance, or if the procedure code is flagged as requiring a tooth in Procedure Code Maintenance. This edit will also be applied if an invalid tooth number is entered.

Future Use - This edit is reserved for future use.

Previous Endo Treatment - Endodontic treatment has previously been performed.

No Previous Root Canal - No prior root canal.

Previously Apicoed - History of apicoed exists on the same tooth.

Root Previously Amputated - History of amputated root on the same tooth.

Amputating Last Root - All other roots have previously been amputated.

Previous Pontic - Pontic already exists for the same tooth.

Tooth Not Missing - Tooth exists.

Previous Abutment - History of a prior abutment.

Tooth Not Erupted - Tooth has not broken through the surface.

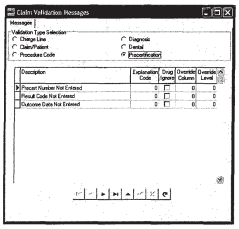
Permanent Has Replaced Primary - Primary tooth no longer exists; permanent tooth has taken its place.

Tooth Chart or Tooth Not Found - The tooth chart does not exist for the patient, or the indicated tooth is not in the tooth chart.

No Init. Proc Code for Concurrent - No record of initial service for this procedure.

Tooth Chart Conflict - Contradictory information between service and tooth chart.

Precertification Edits



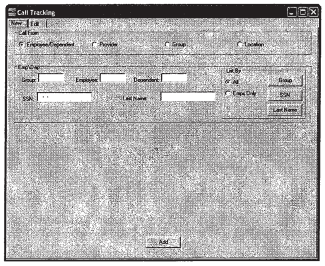
Precert Number Not Entered - A precertification number has not been found on the claim, in which case the following two edits are not applied.

Result Code Not Entered - A precertified claim has no result code.

Outcome Data Not Entered - A precertified claim has no outcome data.

Call Tracking

This option is used maintain a record of calls from employees or their dependents, providers, groups, and group locations. In addition to telephone calls, you can enter and track contacts made by voice mail, e-mail, letters, and faxes. You can view calls by various selection criteria, such as for a specific operator, resolved or unresolved calls, calls over a specified number of days or within a specified time frame. You can further select to have the information displayed in current date, received date, or assigned priority order.



To Add a Call

Use the **Call From** area to identify the type of caller; the applicable fields will then appear on the screen.

If the call is from an employee/dependent, the selection choices will be as shown on the above screen. You can identify the caller in a number of different ways. For example:

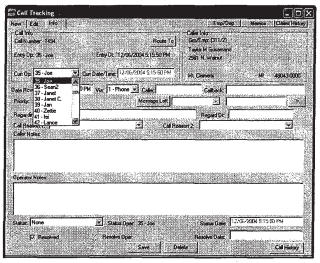
- You can enter the group, employee, and (if applicable) dependent numbers.
- You can enter the employee's or dependent's social security number.
- You can enter a last name and click **Last Name** in the **List By** area to display a list of individuals with that last name from which you can select the appropriate individual.
- You can also use the **List By** area to display a scroll of employees and their dependents (**All**) or employees only (**Emps Only**), listed numerically by group number, numerically by social security number, or alphabetically by last name.

If the call is from a provider, group, or location, the selection criteria will be different but it is used in the same way.

After you have identified the caller, click **Add** to open the **Info** tab.

The **Emp/Dep** button at the upper right of the screen accesses Employee/Dependent Maintenance, the **Claims History** button accesses Claim Inquiry, and the **Memos** button accesses Employee Memo Maintenance.

The **Call Info** area displays a system-generated call number for reference purposes, the initial entry operator number and name, and the date and time the call was entered



Route To - This option will allow you to route a call to another active operator.

Cur Op - From the drop down list, select the operator to whom to route the call.

Cur. Date/Time -The current date and time the call came in. If the call is rerouted, the current date and time will change.

The **Caller Info** area displays the caller's name and address.

The remaining portion of the screen is used as described below.

Date Rcvd - The date and time a call came in. If the date and time are different, they can be changed.

Via - From the drop down list, select the source of the entry: phone, voice mail, e-mail, letter, fax, walk-in, or web transaction.

Caller - The caller's name.

Callback - A free-form message regarding a call back.

Priority - The priority of the call, 0 = lowest through 9 = highest priority.

Message Left - The operator who left a message. If the operator and current date and time were different, they can be manually changed.

Regarding - Free-form message describing the subject of the call.

Regarding Date - The date of the occurrence that prompted the call.

Call Reason 1 - Select the primary reason for the call from the drop-down list. These reasons are set up in System Configuration and Codes, Call Tracking Reasons.

Call Reason 2 - Select the secondary reason for the call from the drop-down list. These reasons are set up in System Configuration and Codes, Call Tracking Reasons.

Caller Notes - Use this area to describe the caller's concern. You have up to 4000 characters.

Operator Notes - Use this area to describe your response to the caller. You have up to 4000 characters.

Status - Select a status from the drop-down list. These statuses are set up in System Configuration and Codes, Call Tracking Status Reasons.

Status Date - The date and time that the current status was set. The default is the current date and time.

Resolved - Check this box when the call has been resolved.

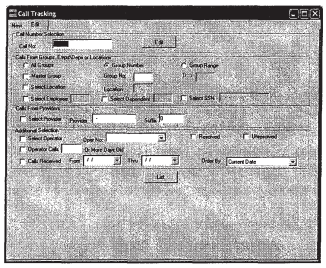
Resolve Oper. - The operator who resolved the call.

Resolve Date - The date and time the call was resolved.

To see a listing of the changes that have been made to the call record, click **Call History**.

To Edit a Call

The **Edit** tab is used to edit a specific call by entering in the assigned call number, or you can elect to list by various options to view all calls from a specific group, location, employee or dependent. You can also view all calls from a specified provider. In addition to the above options, you can further restrict your listing to isolate calls for a specific operator and also indicate if you wish to see only resolved or unresolved calls. You can select to view all calls that are over a specified number of days old, or calls received within a selected time frame.



You can use the **Call Number Selection** area to go directly to a call by entering the call number and clicking **Enter**.

In the **Calls From Groups, Emps\Deps, or Locations**, you can choose to list calls from a specified group, employee or locations.

In the **Calls From Providers** area, you can choose to list all calls from an individual provider.

The **Additional Selections** area allows you to further limit your call selection criteria.

Select Operator/Oper. No. - When checked, lists only the calls received by the selected operator.

Resolved/Unresolved - Check the applicable box to list either resolved or unresolved calls. Leave these boxes blank to list both types of calls.

Operator Calls ___ Or More Days Old - When checked, lists only calls older than the specified number of days.

Calls Received - When checked, lists only calls received during the specified time frame.

Order By - Select the order in which to list the calls:

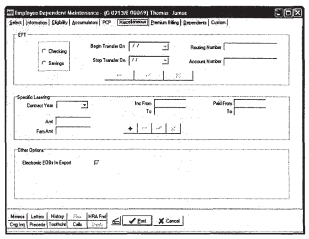
Current Date - The date the call was entered.
Received Date - The date the call was received.
Priority - The priority assigned to the call, 0 being lowest and 9 the highest.

After making your selections, click **List** to display the calls at the bottom of the screen. You can then double-click a call to open the **Info** tab for the call to view or edit the call information.

Miscellaneous

The Miscellaneous tab is used to define bank accounts for EFT processing, as well as define contract information for Specific Lasering.

EFT



Checking / Savings – Select whether the defined account is a Checking or Savings Account.

Begin Transfer On – Enter the date at which the account information is valid.

Stop Transfer On – Enter the date at which the account information is no longer valid. When utilizing the EFT module, payments will automatically become EFT payments for check runs performed between the dates defined in the **Begin Transfer On** and **Stop Transfer On** fields.

Routing Number – Enter the bank's routing number.

Account Number – Enter the employee's bank account number.

Specific Lasering

Contract Year – Select the contract year for which you wish to establish lasering. Only those contract years already defined in Group Maintenance will be available in the drop down list.

Amt – Enter the individual specific amount.

Fam Amt – Enter the family specific amount.

Inc From / To – Enter the Incurred From and To dates for which the contract is effective. If this is a Paid-Only contract, you can leave these fields blank.

Paid From / To – Enter the Paid From and To dates for which the contract is effective. If this is an Incurred-Only contract, you can leave these fields blank.

Other Options

Electronic EOBs In Export- Select this option to elect to send electronic EOBs to the member if you utilize the **Adminisource** check print format.

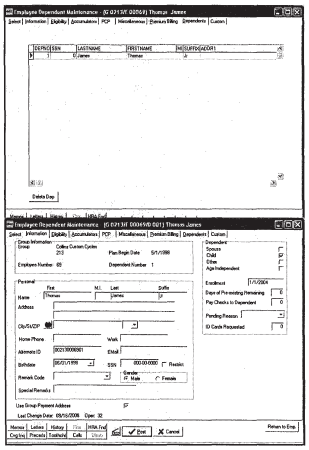
Notes:

Dependents

The **Dependents** tab displays a list of dependents for the employee.

You can add new dependents by clicking the insert button or you can view/edit existing dependents by double-clicking the selected dependent.

Delete Dep – Use this button to permanently delete a dependent from the system. Only dependents without claim activity can be deleted from the system. An "Are you sure?" prompt gives you a final warning before deleting the dependent.



Dependents have their own **Information** tab. If the dependent's address is different from the employee's, you can enter the dependent's address here. When left blank, all correspondence will use the employee's address.

Pay Checks to Dependent - The dependent number entered here will make the check payable to that dependent. For example, if dependent #1 is the employee's ex-spouse, and there is a court order in effect that indicates that reimbursement checks for claims incurred by dependent children are to made payable to the ex-spouse, you would enter "1" in this field for all applicable family members.

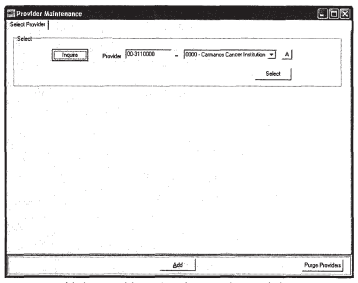
Pending Reason - You may select a pending reason to be attached to the dependent. All claims processed for the dependent will then be pended with the chosen pend code. This pend code will overwrite any pend codes set by the editor.

Notes:

WLT Providers

Provider Maintenance

To view a provider, enter the **Provider** number you wish to select. When you tab out of this field, the drop down list will contain all providers associated with that TIN and you can select a suffixed provider when applicable. Click the **Select** button to proceed.



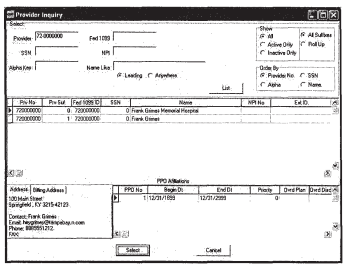
It is recommended that providers be added using their tax ID number as the provider number. If there are multiple providers with the same tax ID number, you can add a suffix number to the provider number. To add a new provider, enter the provider's TIN and then click the **Add** button at the bottom of the screen. When trying to add a provider with a number that is already in the system, the system will notify you and ask if you want to add the provider using that number and the next available suffix.

The **Purge Providers** button at the bottom of the screen is used to permanently delete from the system all providers who have the **Delete at End of Year** field checked on the **Provider Data** tab. Everyone must be out of Provider Maintenance when the purge is performed. Refer to the **Delete at End of Year** field description for more information. This option is only available to a supervisor.

Note: Purging providers is a permanent process, and can result in reporting discrepancies if claims exist for those providers.

Provider Inquiry

The **Inquire** button will execute a provider inquiry and search screen that displays demographic information and PPO affiliations. You can search for providers using their Provider number, Federal 1099 number, SSN, NPI, Alpha Key or search by Name Like. The Name Like function allows you to search for providers by entering a partial name. Name searching with the **Leading** option looks at the first letters of a provider's name to attempt to match your search criteria. For example, use "FIS to locate "FISH", FISCHER, and FISHMAN". When you search with the **Anywhere** option, the search looks anywhere in the provider name for the search criteria you have entered. For example, use "EAST" to locate "EASTLYN", "WEASTLER" and "NORTHEAST HOSPITAL". Once you have entered your search criteria, click the List button to display the results.



Show

Select what information you would like displayed. You can display Active, Inactive or All. All Suffixes allows you to display all provider number suffixes related to a provider number. Roll up will display only the primary providers (suffix zero).

Order By

Select whether you would like the search results listed in Provider No., Alpha, SSN, or Name order.

The first grid will display everyone who meets the selection criteria. The second grid will list all PPO Affiliations for the provider highlighted in the first grid. Both the service address and billing address are displayed on the screen. Once you have located the correct provider, click the **Select** button or double click on the record to display the Provider Data information.

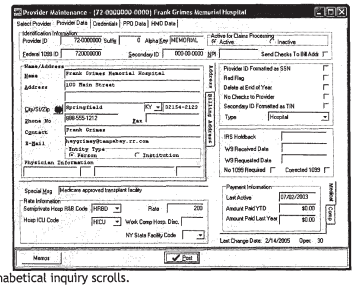
Provider Data

To access a provider's information, either double click the provider or select the provider and click Select on the bottom of the Inquiry screen. This will take you to the Provider Data tab. You will be able to view and update the provider name and address information, billing address, payment information, tax information, and whether the provider is currently active.

It is recommended that providers be added using their tax ID number as the provider number. If there are multiple providers with the same tax ID number, you can add a suffix number to the provider number. When trying to add a provider with a number that is already in the system, the system will notify you and ask if you want to add the provider using that number and the next available suffix.

Identification Information:

Provider ID - The provider identification number used in conjunction with the Suffix is a unique key for processing. Usually, this number is the same as the tax identification number.



Suffix - The suffix for the provider's identification number. If multiple providers have the same Provider ID, a suffix is assigned to subsequent providers as a unique key to be used in processing.

Alpha Key - The most significant eight characters of the provider's name (usually the first 8 characters of the last name for providers, or the first 8 characters of the most significant word in a hospital or clinic's name). This is used for alphabetical inquiry scrolls.

Federal 1099 ID - Enter the federal tax identification number of the organization that has 1099 responsibility. If the **Federal 1099 ID** is not the same as the provider's tax identification number, the **Federal 1099 ID** must also be established as a Provider ID (suffix zero) on the system. If this is a suffixed provider, this field is not available and 1099 information will be reported under the primary provider's Federal 1099 ID.

Secondary ID - If the provider has both a Federal TIN and a social security number, the social security number can be entered as a Secondary ID.

NPI - The provider's National Provider Identification number.

Send Checks to Bill Addr - If selected, checks will be addressed to the provider's billing address. Otherwise, they will go to the provider's service address.

Entity Type - Indicate whether the provider is a **Person** or an **Institution**. This will be needed when exporting claims in an 837 format in order to determine the correct formatting of the provider information.

Physician Information - If the **Entity Type** "Person" was selected, enter the physician's first name, middle initial, last name, and suffix separately.

Special Msg - If applicable, a free-form message (up to 40 characters) that will be displayed during claims entry.

Type - Select the applicable Provider Type as established in System Configuration & Codes. This field is required if you are assigning Coverage Codes to procedures based on the Provider Type and is optional for reporting purposes. Provider types can also be used for 1099 reporting to determine that payments for certain providers should be reported in box 3 instead of box 6.

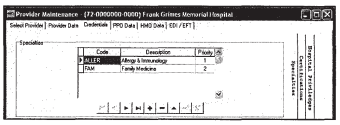
Notes:

Credentials

The **Credentials** tab allows you to view and update provider Specialties, Hospital Privileges, Certifications, State/Federal Licenses, and Malpractice Information. You can also allow EDI access by a specified EDI clearinghouse.

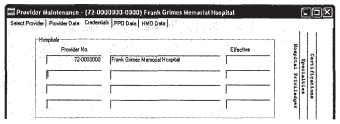
Specialties

An unlimited number of user-defined specialties or medical fields of practice can be assigned to providers. Priority levels are from 1-99, with 1 being the highest priority, and are used to dictate the order the specialties are displayed on the screen. Specialty codes are entered and maintained in System Configuration & Codes.



Hospital Privileges

You can define up to four hospitals at which the provider has hospital privileges, and the effective dates for each.



Certifications

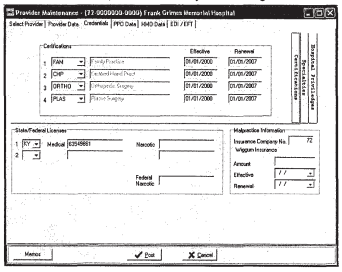
Establish up to four user-defined provider board certifications, as defined in System Configuration & Codes, and the effective and renewal dates for each.

State/Federal Licenses

Identify up to two states in which the provider is licensed to practice, along with their respective Medical and Narcotic license numbers, and the provider's Federal Narcotic license number.

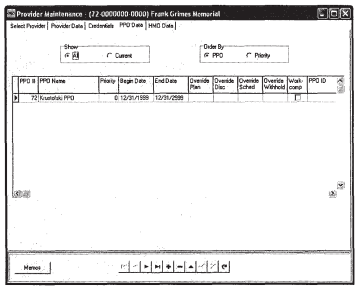
Malpractice Information

Enter the user-defined insurance company number, as established in Insurance Company Maintenance, of the insurance company providing malpractice insurance, including the dollar amount of the insurance available and the effective and renewal dates.



PPO Data

The **PPO Data** tab allows you to view and attach PPO affiliations to your providers. You can attach any number of PPOs to the provider, and define the beginning and ending dates of the provider's participation in each PPO. If the provider has negotiated a different standard discount or different parameters from the standard plan of benefits, these can also be defined.



EDI/EFT

EDI

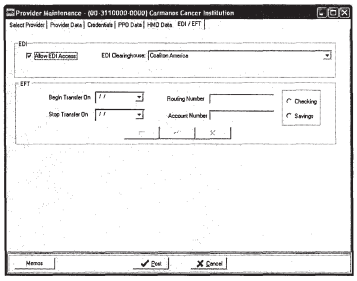
Allow EDI Access - Select this option to allow electronic claims to come into the system for this provider.

EDI Clearinghouse - From the drop down list, select which clearinghouse this provider will use.

EFT

Checking / Savings – Select whether the defined account is a Checking or Savings Account.

Begin Transfer On – Enter the date at which the account information is valid.



Stop Transfer On – Enter the date at which the account information is no longer valid. When utilizing the EFT module, payments will automatically become EFT payments for check runs performed between the dates defined in the **Begin Transfer On** and **Stop Transfer On** fields.

Routing Number – Enter the bank's routing number.

Account Number – Enter the employee's bank account number.

Quality Assurance

CorrectCare
INTEGRATED HEALTH

QUALITY CONTROL
CLAIMS DEPARTMENT

New processor holds-All claims processed are placed on processor hold and claims are audited at 100% until accuracy rate of 99% is maintained. Claims are reviewed and audited by the Claims Supervisor. This is done on a pre-payment basis.

Adjudicator limits-Adjudicator limits are setup in the claim system, all claims for the set amount and above are placed on hold to be reviewed prior to release. When a processor is removed from the new processor hold an adjudicator payment limit of $2000.00 is placed on the adjudicator. When the adjudicator maintains an error rate of 99% for a period of 6 months the adjudicator limit will be increased to $5000.00. All paid amounts of $5000.00 - $9999.00 are reviewed and released by the claims supervisor. All paid amounts of $10,000.00 and over are reviewed and released by the Claims Manager. This is done on a pre-payment basis.

Fund lock review-Each group will have 1 fund lock per week; this fund lock is created and reviewed by the Claims Manager. The following are reviewed prior to the funding request being completed; correct inmate, correct provider, payment amount, and authorization on file for procedure. This is done on a pre-payment basis.

Post payment Quality Assurance-See policy attached which is done on a pre and post payment basis.

I. AUTHORITY

This policy and procedure is issued under the authority of the Governing Board of CorrectCare, Inc. in order to adopt rules and regulations for Quality Assurance in claims administration.

II. PURPOSE

To provide guidelines for Quality Assurance.

III. APPLICABILITY

This policy shall be applicable to all employees in the claims administration department.

IV. DEFINITIONS

Quality Assurance: means a set of procedures designed to ensure that quality Standards and processes are adhered to and that the final outcome meets or exceeds the required technical and performance requirements.

Program Monitor: Claims Manager

V. POLICY

Correct Care's Claims Administration department conducts client specific and/or universal audits as prompted by indicators and selected data points in order to assure quality standards are being met for the organization and its clients.

VI. PROCEDURES

SELECTING THE AUDIT SAMPLE

1. The sample size will be 3 - 5% of the total claims volume received.

2. The random claim selection function will be set in the WLT claims system for the sample size percentage above.

3. The sample will be selected on pre and post-payment basis.

COMPLETING THE AUDIT WORKSHEET

1. The Quality Assurance Program Medical/Dental Audit worksheet will be completed. (Attachment A)

2. The top portion of the form is used to identify the claim being audited, Processor, Employee Name, Employee SSN, Claimant, and relationship.

Audit Worksheet Categories

Twelve general categories are included on the worksheet; following is a listing of the error types which are to be identified by each of the categories.

1. Employee Eligibility:

- Charges incurred prior to the employee's effective date.
- Charges incurred after the employee's termination date.
- Charges are for a pre-existing condition.
- Charges may indicate misrepresentation.
- Employee did not satisfy actively at work provision.
- Employee did not meet full-time employee definition.

2. Dependent Eligibility:

- Charges incurred prior to dependent's effective date.
- Charges incurred after the dependent's effective date.
- Not an eligible dependent as defined by the contract.
- Employee has single coverage only.
- Charges are for a pre-existing condition.
- Charges may indicate misrepresentation.

3. Deductibles: (Single or Family)

- Deductible not satisfied, charges paid.
- Excess deductible taken.
- Separate deductible required, not taken.

4. Coinsurance:

- Charges paid at wrong coinsurance (basic, major medical, PPO)
- Ineligible coinsurance applied to out-of-pocket.
- Eligible coinsurance not applied to out-of-pocket.
- Out-of-pocket maximum exceeded.

5. Policy Maximum:

- Benefits exceeded policy dollar maximum.
- Benefits exceeded policy frequency maximum.
- Reasonable and customary not applied or incorrect.

6. Cost Containment:

- Hospital bills not referred for hospital Audit.
- Pre-certification not obtained.
- Second surgical opinion not obtained.
- PPO procedures not followed.
- Any incentives / penalties not applied.
- Subrogation / right of reimbursement not pursued.

7. Provider Data

- Incorrect provider entered.
- TIN required, not entered.
- Assignment incorrect.
- Incorrect PPO applied to claim.
- Provider billing address not updated.

8. Covered Expense:

- Payment made for a non covered expense, cosmetic, routine,
- Preventive, personal comfort, Worker's Compensation, etc. Payment made for an expense previously considered.
- A covered expense was incorrectly denied.

9. COB:

- Potential other coverage not investigated.
- Incorrect COB calculation.

10. Data Entry Error:

- Any information provided by the claim which is entered incorrectly, name, address, date of service, amount of charge, etc.

11. Administrative Procedure

- Any non-contractual, administrative procedure not followed, note screen not correctly updated, failure to refer a claim to a higher authority level, follow-up procedures not followed, etc.

12. Missing Documentation:

- Failure to obtain necessary documentation, completed claim form, operative report, confirmation of student status, first date of treatment, etc.

Financial and Procedural Errors

1. The auditor will determine if the error is a financial error or a procedural error.

2. A financial error is confirmed when a review of the claim documents substantiate that an overpayment or underpayment has been made on the claim. A financial error is unconfirmed when there is insufficient documentation available on which to determine a financial error has occurred. If an overpayment or underpayment cannot be confirmed with the available claims documentation or a phone call, a procedural error for missing documentation will be charged.

Error Description

1. For each box checked, the section entitled Error Description will have a corresponding entry, which briefly describes the specific error identified. When more than one error is identified on a claim, the description will include the category number affected.

2. This information will have two uses. First, it will be used to communicate to the examiner the type of error being charged. Secondly, this data will be used as part of the analysis and action planning.

Recording Individual Claim Results

1. In the final section of the worksheet, the auditor records the overall results of the audit on the claim. The auditor will also indicate dollars overpaid or underpaid the number of procedure errors and any unconfirmed errors.

2. The auditor will sign and date the audit worksheet.

Communication: Auditor/Examiner

1. Following the audit, and prior to accumulating the results, all errors will be communicated to the examiner responsible by providing them with a copy of the audit worksheet.

2. The examiner has an opportunity to respond if they disagree with the auditor's decision or they has additional information concerning the error charged.

3. If an error exists, the examiner will be aware of the type of error made and the frequency of occurrence, and will process all corrections.

4. All errors will be corrected and returned within 2 business days from the time the audit worksheet is given to the examiner.

5. All audit worksheets not returned within the above time frame will be considered a confirmed error.

ACCUMLATING AND REPORTING AUDIT RESULTS

There will be three reports for accumulating and reporting the audit results, Examiner Level report, Unit Level Report and Department Level report.

Examiner Level Report

1. The examiner level report will be used to track information at the examiner level. It is designed to capture information about the performance of each examiner and the specific types of errors identified. This report will be the basis for action planning as well as to provide back up for performance evaluations. (Attachment B)

2. This report will be used to roll-up results by week; this report will be completed at the end of each week. At the end of the month, the weekly reports will be rolled up to produce a month-end report. At the end of three months, the monthly Reports will be rolled-up to produce a quarterly report.

Unit Level Report

1. This report will be used to compile information from the examiner level reports and will capture information about the specific errors identified from the unit as a whole. (Attachment C)

2. This report will identify areas of weakness by unit which could not be identified on the individual examiner level reports.

Department Level Report

1. The department level reports will be used to communicate overall office performance results to management. This report will utilize industry standard measurements of performance, Financial Accuracy and Claim Payment accuracy. (Attachment D)

Analysis of Results

The audit results will report on Financial Accuracy and Claim Payment Accuracy. The Department Level report will be provided to upper management on a monthly, quarterly and yearly basis.

Financial Accuracy

Financial Accuracy is obtained by adding over and underpayments, without regard for plus or minus application and subtracting that total from the total paid dollars audited. This result will then be divided by the total paid dollars audited.

The financial accuracy standard expected is 99%, if the overall financial accuracy standard is less than 99% on the audit sample selected, a corrective action plan will be put into place until the standard is met.

Claim payment Accuracy

1. Claim payment accuracy is the total number of transactions handled correctly, without dollar errors or procedural errors, divided by the total number of transactions audited.

2. The claim payment accuracy standard is 98%, if the overall claim payment accuracy standard is less than 98%; a corrective action plan will be put into place until that standard is met.

CORRECTIVE ACTION PLANNING

1. A written corrective action plan will be implemented and will involve intervention at the examiner level when the expected Financial Accuracy and Claim Payment Accuracy standards have fell below the required standards.

2. Problem areas will be addressed with the examiner/unit immediately following identification of the weakness to minimize repetitive errors.

3. Copies of all applicable policy and procedure guidelines will be provided to the examiner/unit necessary for improvement in the problem areas.

4. Follow up focused audits of selected claims will be concentrated in the problem areas identified on the random audit until the expected standards have been met.

Approved by: _____ **Date:** _____

Approved by: _____ **Date:** _____

Explanation Codes

Explanation Codes

DESCNO	DESCRIPTION
0	
1	Applied to Deductible
2	Co-insurance Applied
3	Applied to Deduct & Co-Insurance
4	Expense Not Covered by Plan
5	Reserve For Future Use
6	Inmate Not Eligible
7	Exceeds Maximum Plan Allowance
8	Charge Exceeds UCR
9	Exceeds Filing Time Limit
10	Exceeds Visit Limit
11	Employee/Provider Split Payment
12	COB Savings Applied
13	PPO Benefits applied.
14	Exceeds Plan Payment Limit
15	Co-Benefits Applied
16	Stop Loss Met This Line
17	Discount On Payment
18	Day denied on precert.
19	Reserved For Future Use
20	Editor Denial
21	Denied Amt Pending Addtl Fnding
22	Fund Limit Reached
23	New York Surcharge
24	Duplicate Charge
25	Repriced by Coaliation America
26	Over-age Dependent
27	Claim Adjustment
28	Claim to be Refunded
29	Claim to be Reinsured
30	Claim to be Reviewed
31	Repriced by Beech Street
32	Paid by previous carrier
33	Exceeds Contracted Case Rate
34	Exceeds Contracted DRG Rate
35	Exceeds Contracted Per Diem Rate
36	Duplicate of a corrected claim.
37	Repriced by Correct Care for OH
38	Medicare non covered procedure
39	Non par provider, no discount.
40	Additional payment.
41	No authorization on file.
42	Member responsible for charges.
43	Denied for Workers Comp.
44	Non covered, member responsible.
45	Refile with Physcians Name.
46	Prior to effective date of group
47	Submit itemized statement.
48	Inclusive with per diem rate.
49	Claim sent for bill audit.
50	Submit entire medical record.
51	Amount previously billed.
52	Bluegrass Family Health discount
53	PPO Next Contracted Rate.
54	NPPN Direct discount.
55	PPO of Kentucky discount.
56	Healthspan Contracted rate.
57	Not a state inmate.
58	Indigent paid at medicaid rate.
59	Charges denied per bill audit.
60	Service denied per Authorization
61	MRI Provider Strategies discount
62	PPO of Indiana negotiated rate.
63	Paid with negotiated rate.
64	NPPN AC negotiated rate.
65	Late charges are non covered.
66	TRPN negotiated rate
67	Other coverage primary
68	Claim not eligible for payment
69	Facility records required.
70	MRI National negotiated rate
71	MCS/PPONext negotiated rate
72	PREMIER ACCESS negotiated rate
73	ASMED HEALTH PARTNERSHIP
74	NATIONAL PROV negotiated rate
75	PRIMARY HEALTH negotiated rate
76	UCS Negotiated discount.
77	First Health discount agreement.
78	Provider Strategies discount.
79	Beech Street discount agreement.
80	Multiplan discount agreement.
81	Interplan negotiated rate.
82	Corrected EOB
83	Void & Reissue check.
84	NPPN/Interplan discount.
85	NPPN/PPO NEXT discount.
86	MCS/PPO NEXT discount.
87	Assoc Primary Care Phy discount
88	CCN discount agreement.
89	Health Payers LTD discount.
90	HPO/Primary Health Srv discount
91	MEDICAL RESOURCE discount
92	NPPN Negotiated discount.
93	PPOIN/ProHealth discount
94	1st Medical Network discount
95	Claim denial upheld
96	Medical Furlough
97	Not responsible contract inmate.
98	TRPN/NPN discount amount.
99	Submit MAR, breakdown of charges

100	CHA preferred provider discount.
101	Prior to groups effective date.
102	Dates do not match authorization
103	Charges do not match auth.
104	Submit start and stop time.
105	Incomplete records received.
106	Additional information required.
107	Corrected Claim received.
108	Does not change pay amount.
109	Service does not match auth.
110	National Provider Network
111	NPPN/SIG. OF TN
112	Discount result bill negotiation
113	Provider paid as surgeon.
114	Cannot bill asst. surgeon chgs.
115	Sent for retro review.
116	Workers Comp carrier to pay.
117	Other primary coverage.
118	TRPN-Managed Care Strat negotiat
119	NPPN Discount amount.
120	Liver Biopsies billed by hosp.
121	Inmate on parole.
122	NPPN/Galaxy Health Network
123	Invalid CPT code resubmit.
124	OHIO PREFERRED NETWORK
125	Claim was sent for retro review
126	Baptist Health Services Group
127	Corrected bill charge
128	NPPN/Assoc of Primary Care Phys.
129	NPPN/Ohio Preferred Network
130	Diagnosis not valid for sex.
131	Newborn care is non covered.
132	NPPN/HEALTHSPAN
133	NPPN/PROVIDER SELECT
134	Phase 3 Case Rate
135	NPPN/PHYSICIANS NETWORK
136	NPPN/THE INITIAL GROUP
137	Included in case rate
138	NPPN/HEALTH PAYERS ORG (HPO)
139	Inclusive with DRG rate
140	Submit pacemaker check report.
141	Submit H & P documentation.
142	Coalition America discount
143	Additional clinical required.
144	Paid at ground transport rate.
145	Authorization Denied.
146	No allowance for modifier 26.
147	CorrectCare Negotiated Discount
148	NPPN/NATIONAL HOSP NETWORK
149	Billed under incorrect Tax ID
150	Convenience items non covered
151	After hours charge is not covere

152	service not received
153	Invalid Age vs CPT code
154	Invalid Sex vs CPT code
155	Invalid place of service
156	Invalid modifier code
157	Invalid Diagnosis code
158	Invalid Age vs Diagnosis
159	Unacceptable primary Diagnosis
160	Incidental procedure
161	Charge included in another code
162	Procedure not valid for date.
163	Included in global time period
164	Possible catastrophic
165	Included in Global allowance
166	Not Medically Necessary.
167	Elective Procedure non covered.
168	Cosmetic procedure non covered.
170	Non specific Primary Diagnosis.

Modifier Codes

Symbols

- ▲ Revised code
- ● New code
- ►◄ New or revised text
- Reference to *CPT Assistant, Clinical Examples in Radiology*, and *CPT Changes*
- ✚ Add-on code
- ⊘ Exemptions to modifier 51
- ⊙ Moderate sedation
- ⌿ Product pending FDA approval

Modifiers (See Appendix A for Definitions)

- **21** Prolonged evaluation and management services
- **22** Unusual procedural services
- **23** Unusual anesthesia
- **24** Unrelated evaluation and management service by the same physician during a postoperative period
- **25** Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
- **26** Professional component
- **32** Mandated services (Payor requires Pre-cert be done)
- **47** Anesthesia by surgeon
- **50** Bilateral procedure
- **51** Multiple procedures
- **52** Reduced services
- **53** Discontinued procedure
- **54** Surgical care only
- **55** Postoperative management only
- **56** Preoperative management only
- **57** Decision for surgery
- **58** Staged or related procedure or service by the same physician during the postoperative period
- **59** Distinct procedural service
- **62** Two surgeons
- **63** Procedure performed on infants
- **66** Surgical team
- **76** Repeat procedure by same physician
- **77** Repeat procedure by another physician
- **78** Return to the operating room for a related procedure during the postoperative period
- **79** Unrelated procedure or service by the same physician during the postoperative period
- **80** Assistant surgeon
- **81** Minimum assistant surgeon
- **82** Assistant surgeon (when qualified resident surgeon not available)
- **90** Reference (outside) laboratory
- **91** Repeat clinical diagnostic laboratory test
- **99** Multiple modifiers

Physical Status Modifiers

- **P1** A normal healthy patient
- **P2** A patient with mild systemic disease
- **P3** A patient with severe systemic disease
- **P4** A patient with severe systemic disease that is a constant threat to life
- **P5** A moribund patient who is not expected to survive without the operation
- **P6** A declared brain-dead patient whose organs are being removed for donor purposes

Modifiers Approved for Hospital Outpatient Use Level I (CPT)

- **25** Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
- **27** Multiple outpatient hospital E/M encounters on the same date
- **50** Bilateral procedure
- **52** Reduced services
- **58** Staged or related procedure or service by the same physician during the postoperative period
- **59** Distinct procedural service
- **73** Discontinued outpatient procedure prior to anesthesia administration
- **74** Discontinued outpatient procedure after anesthesia administration
- **76** Repeat procedure by same physician
- **77** Repeat procedure by another physician
- **78** Return to the operating room for a related procedure during the postoperative period
- **79** Unrelated procedure or service by the same physician during the postoperative period
- **91** Repeat clinical diagnostic laboratory test

Level II (HCPCS/National)

- **LT** Left side (used to identify procedures performed on the left side of the body)
- **RT** Right side (used to identify procedures performed on the right side of the body)
- **CA** Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
- **E1** Upper left, eyelid
- **E2** Lower left, eyelid
- **E3** Upper right, eyelid
- **E4** Lower right, eyelid
- **FA** Left hand, thumb
- **F1** Left hand, second digit
- **F2** Left hand, third digit
- **F3** Left hand, fourth digit
- **F4** Left hand, fifth digit
- **F5** Right hand, thumb
- **F6** Right hand, second digit
- **F7** Right hand, third digit
- **F8** Right hand, fourth digit
- **F9** Right hand, fifth digit
- **GA** Waiver of liability statement on file
- **GG** Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
- **GH** Diagnostic mammogram converted from screening mammogram on same day
- **LC** Left circumflex, coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- **LD** Left anterior descending coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- **RC** Right coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- **QM** Ambulance service provided under arrangement by a provider of services
- **QN** Ambulance service furnished directly by a provider of services
- **TA** Left foot, great toe
- **T1** Left foot, second digit
- **T2** Left foot, third digit
- **T3** Left foot, fourth digit
- **T4** Left foot, fifth digit
- **T5** Right foot, great toe
- **T6** Right foot, second digit
- **T7** Right foot, third digit
- **T8** Right foot, fourth digit
- **T9** Right foot, fifth digit

POS Codes

Place-of-Service Codes for Professional Claims

Listed below are place-of-service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (eg, Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (effective 10/1/05)
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (eg, emergency shelters, individual, or family shelters).
05	Indian Health Service freestanding facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 freestanding facility	A facility or location, owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location, owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison-correctional facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by federal, state, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility, military treatment facility, community health center, state or local public health clinic, or intermediate care facility, where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (eg, medication administration) (effective 4/1/04)
15	Mobile unit	A facility or unit that moves from place to place and is equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent care facility	Location, distinct from a hospital emergency department, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room—hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility also refers to certain former US Public Health Service facilities now designated as uniformed service treatment facilities.
27-30	Unassigned	N/A
31	Skilled nursing facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance—land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—air or water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place-of-service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric facility—partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the community mental health center's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24-hour-a-day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/mentally retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or skilled nursing facility.
55	Residential substance abuse treatment facility	A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Nonresidential substance abuse treatment facility	A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims or paper claims or by using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility, other than a hospital, that provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician. (effective 10/1/03)
72	Rural health clinic	A certified facility located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

Revenue Codes

Revenue Codes

Code Number	Description
100	All Incl R&B/Anc
101	All Incl R&B
110	Room-Board-Pvt
111	Med-Sur-Gy/Pvt
112	OB/Pvt
113	Peds/Pvt
114	Psych/Pvt
115	Hospice/Pvt
116	Detox/Pvt
117	Oncology/Pvt
118	Rehab Room & Board
119	Other/Pvt
120	Room-Board/Semi-Private
121	Med-Sur-Gy-2Bed
122	OB/2Bed
123	Peds/2Beds
124	Psych/2Bed
125	Hospice/2Bed
126	Detox/2Bed
127	Oncology/2Bed
128	Rehab
129	Other/2Bed
130	Room-Board/3&4Bed
131	MedD-Sur-Gy/3&4 Bed
132	OB/3&4 Bed
133	Peds/3&4 Bed
134	Psych/3&4 Bed
135	Hospice/3&4 Bed
136	Detox/3&4 Bed
137	Oncology/3&4 Bed
139	Other/3&4 Bed
140	Room-Board/Pvt/DLX
141	Med-Sur-Gy/DLX
142	OB/DLX
143	Peds/DLX
144	PSYCH/DLX
145	HOSPICE/DLX
146	DETOX/DLX
147	ONCOLOGY/DLX
148	Rehab
149	OTHER/DLX
150	ROOM-BOARD/WARD
151	MED-SUR-GY/WARD
152	OB/WARD
153	PEDS/WARD
154	PSYCH/WARD
155	HOSPICE/WARD
156	DETOX/WARD
157	ONCOLOGY/WARD
158	REHAB
159	OTHER/WARD

Revenue Codes

160	R&B
161	OTHER PHYSICAL THERAPY
164	R&B/STERILE
167	R&B/SELF
169	R&B/OTHER
170	NURSERY
171	NURSERY/NEWBORN
172	NURSERY/PREMIE
173	SICK BABY
175	NURSERY/ICU
176	
179	NURSERY/OTHER
180	LEAVE OF ABSENCE
181	
182	LOA/PT CONV
183	LOA/THERAPEUTIC
184	LOA/ICF/MR
185	LOA/NURS HOME
189	LOA/OTHER
200	INTENSIVE CARE (ICU)
201	ICU/SURGICAL
202	ICU/MEDICAL
203	ICU/PEDS
204	ICU/PSYCH
205	
206	POST ICU
207	ICU/BURN CARE
208	ICU/TRAMA
209	ICU/OTHER
210	CORO. CARE (CCU)
211	CCU/MYO INFARC
212	CCU/PULMONARY
213	CCU/TRANSPLANT
214	POST CCU
219	CCU/OTHER
220	SPECIAL CHARGES
221	ADMIT CHARGE
222	TECH SUPPT CHARGE
223	UR CHARGE
229	OTHER SPECIAL CHARGES
230	NURSING INCREM
231	NUR INCR/NURSERY
232	NUR INCR/OB
233	NUR INCR/ICU
234	NUR INCR/CCU
235	NUR INCR/HOSPICE
239	NUR INCR/OTHER
240	ALL INCL ANCIL
241	
249	Incremental Nursing Other
250	PHARMACY GENERAL
251	DRUGS/GENERIC

Revenue Codes

252	DRUGS/NONGENERIC
253	DRUG/TAKEHOME
254	BLOOD/PLASMA
255	BLOOD/OTHER
256	DRUGS/EXPERIMT
257	DRUGS/NONPSCRPT
258	IV SOLUTIONS
259	DRUGS/OTHER
260	IV THERAPY
261	INFUSION PUMP
262	IV THER, PHARM SRVCS
263	IV THER, DRG/SPPLY DELIVERY
264	IV THER, SUPPLIES
269	OTHER IV THERAPY
270	MED-SUR SUPPLIES
271	MED-SUR SUPPLIES
272	STERILE SUPPLY
273	TAKEHOME SUPPLY
274	PROSTHETIC DEV
275	PACE MAKER
276	INTRAOCULAR LENS
277	O2/TAKEHOME
278	SUPPLIES/IMPLANTS
279	SUPPLY/OTHER
280	ONCOLOGY
289	OTHER ONCOLOGY
290	MED EQUIP/DURAB
291	MED EQUIP/RENT
292	MED EQUIP/PURCH
293	PURCHASE USED EQUIPMENT
294	SUPPLIES/DRUGS FOR DME
299	MED EQUIP/OTHER
300	LABORATORY (LAB)
301	LAB/CHEMISTRY
302	LAB/IMMUNOLOGY
303	LAB/RENAL HOME
304	LAB/NR DIALYSIS
305	LAB/HEMATOLOGY
306	LAB/BACT-MICRO
307	LAB/UROLOGY
309	LAB/OTHER
310	PATHOLOGY LAB
311	PATHOL/CYTOLOGY
312	PATHOL/HYSTOL
314	PATHOL/BIOPSY
319	PATHOL/OTHER
320	DX X-RAY
321	DX X-RAY/ANGIO
322	ARTHROGRAPHY
323	DXX-RAY CHEST
324	DX X-RAY CHEST
329	DX X-RAY/OTHER

Revenue Codes

330	RX X-RAY
331	CHEMOTHER/INJ
332	CHEMOTHER/ORAL
333	RADIATION RX
335	CHEMOTHERP-IV
339	RX X-RAY/OTHER
340	NUCLEAR MEDICINE
341	NUC MED/DX
342	NUC MED/RX
343	NUC MED DX RADIOPHARMA
349	NUC MED/OTHER
350	CT SCAN
351	CT SCAN/HEAD
352	CD SCAN/BODY
359	CT SCAN/OTHER
360	OPERATING ROOM SERVICES
361	OR/MINOR
362	OR/ORGAN TRANS
367	OR/KIDNEY TRANS
368	
369	OR/OTHER
370	ANESTHESIA
371	ANESTHESIA
372	INCIDENT TO OTHER DIAGNOS
374	ANESTHE/ACUPUNC
379	ANESTHE/OTEHR
380	BLOOD
381	BLOOD/PKD RED
382	BLOOD/WHOLE
383	Hospital Misc.
389	BLOOD/OTHER
390	BLOOD/STOR-PROC
391	BLOOD/ADMIN
399	BLOOD/OTHER STOR
400	IMAGE SERVICE
401	MAMMOGRAPHY
402	ULTRASOUND
403	SCREENING MAMMOGRAPHY
404	PET SCAN
409	OTHER IMAGE SERV
410	RESPIRATORY SERVICE
412	INHALATION SERV
413	HYPERBARIC O2
419	OTHER RESPIR SERVICE
420	PHYSICAL THERAPY
421	PHYSICAL THERP/VISIT
422	HOURLY CHARGE
423	GROUP RATE
424	PHYSICAL THERP/EVAL
429	OTHER PHYSICAL THERAPY
430	OCCUPATIONAL THERAPY
434	OCCUPATIONAL THERAPY

Revenue Codes

439	OTHER OCCUPATIONAL THERAPY
440	SPEECH PATHOL
444	SPEECH PATH
449	OTHER SPEECH PATH
450	EMERGENCY ROOM
451	ER/EMTALA
452	ER/BEYOND EMTALA
456	URGENT CARE
459	OTHER EMERGENCY ROOM
460	PULMONARY FUCNTION
469	OTHER PULMONARY FUNCTION
470	AUDIOLOGY
471	AUDIOLOGY/DX
472	AUDIOLOGY//RX
479	OTHER AUDIOLOGY
480	CARDIOLOGY
481	CARDIAC CATH LAB
482	STRESS TEST
483	ECG
489	OTHER CARDIOL
490	AMBULATORY SURGERY
499	OTHER AMBUL SURGERY
500	ADDITIONAL CHARGES
509	OTHER
510	CLINIC
511	CHRONIC PAIN CENTER
512	DENTAL CLINIC
516	URGENT CARE CLINIC
519	OTHER CLINIC
520	FREESTAND CLINIC
521	RURAL/CLINIC
522	RURAL/HOME
523	FAMILY PRACTICE
529	OTHER FREESTAND CLINIC
530	OSTEOPATH SERVICES
531	OSTEOPATH RX
539	OTHER OSTEOPATH THERAPY
540	AMBULANCE
541	AMBULANCE SUPPLIES
542	AMBULANCE MED TRANSPORT
543	AMBULANCE HEART MOBILE
544	AMBULANCE OXYGEN
545	AIR AMBULANCE
546	NEONATAL AMBULANCE
547	PHARMACY
548	TELEPHONE TRANSMISSION
549	OTHER AMBULANCE
550	SKILLED NURSING
551	SKILLED NURSE VISIT
560	MED SOCIAL SERVICES
569	OTHER
570	AIDE/HOME HEALTH

Revenue Codes

579	OTHER
580	VISIT/HOME HEALTH
581	VISIT CHARGE
582	HOURLY RATE
589	OTHER
590	UNIT/HOME HEALTH
591	
592	OUTPATIENT SERVICES
610	MAGNETIC IMAGE
611	MRI BRAIN
612	MRI SPINAL CORD
614	MRI OTHER
615	MRA HEAD AND NECK
618	MRA
621	MED/SURG INCIDENTAL RAD
622	MED/SURG INCIDENTAL ODX
624	SURGICAL SUPPLIES
634	EPO UNDER 10000 UNITS
635	EPO OVER 10,000 UNITS
636	DRUGS/DETAIL CODE
637	SELF ADMINISTRABLE DRUGS
681	TRAUMA LEVEL 1
683	TRAUNA LEVEL 3
700	CAST ROOM
709	OTHER CAST ROOM
710	RECOVERY ROOM
719	OTHER RECOVERY ROOM
720	DELIVERY ROOM/LABOR
721	LABOR
722	DELIVERY ROOM
723	CIRCUMCISION
724	BIRTHING CENTER
729	OTHER/DELIVERY-LABOR
730	EKG/ECG
731	HOLTER MONITOR
732	TELEMETRY
739	OTHER EKG/ECG
740	EEG
749	OTHER EEG
750	GASTRO INTESTINAL SERVICE
759	OTHER GASTRO INTESTINAL
760	OBSERVATION ROOM
761	TREATMENT ROOM
762	OBSERVATION ROOM
771	ADMIN OF VAC
790	LITHOTRIPSY
800	RENAL DIALYSIS
801	DIALYSIS INPT
802	DIALYSIS/INPT/PER
803	DIALYSIS/INPT/CARD
804	DIALYSIS/INPT/CCPD
809	DIALYSIS/INPT/OTHER

Revenue Codes

810	KIDNEY ACQUISIT
811	KIDNEY/LIV
812	KIDNEY/CADAVER
819	KIDNEY/UNKNOWN
820	HEMO/OP OR HOME
821	HEMO/COMPOSITE
822	HEMO/HOME/SUPPL
823	HEMO/HOME/EQUIP
824	HEMO/HOME/100%
825	HEMO/HOME/SUPSERV
829	HEMO/HOME/OTHER
830	PERTNL/OP OR HOME
831	PERTNL/COMPOSITE
832	PERTNL/HOME SUPPL
833	PERTNL/HOME/EQUIP
834	PERTNAL/HOME/100%
835	PERNTL/HOME/SUPSERV
839	PERTNL/HOME/OTHER
840	CARD/OP OR HOME
841	CARD/COMPOSITE
842	CARD/HOME/SUPL
843	CARD/HOME/EQUIP
844	CARD/HOME/100%
845	CARD/HOME/SUPSERV
849	CARD/HOME/OTHER
850	CCPD/OP OR HOME
851	CCPD/COMPOSITE
852	CCPD/HOME/SUPPL
853	CCPD/HOEM/EQUIP
854	CCPD/HOME/100%
855	CCPD/HOME/SUPSERV
859	CCPD/HOME/OTHER
880	DIALYSIS/MISC
881	DIALYSIS/ULTRAFILT
882	HOME DIALYSIS AID VISIT
889	OTHER
890	DONOR BANK
891	DONOR BANK/BONE
892	DONOR BANK/ORGAN
893	DONOR BANK/SKIN
899	OTHER DONOR BANK
900	PSYCH TREATMENT
901	ELECTRO SHOCK
902	MILIEU THERAPY
903	PLAY THERAPY
904	ACTIVITY THERAPY
909	OTHER PSYCH RX
910	PHYCH SERVICES
911	PSYCH/REHAB
912	PSYCH/DAYCARE
913	PSYCH/NIGHTCARE
914	PSYCH/INDIV RX

Revenue Codes

915	PSYCH/GROUP RX
916	PSYCH/FAMILY RX
917	PSYCH/BIOFEED
918	PSYCH/TESTING
919	PSYCH/OTHER
920	OTHER DX SVS
921	PERI VASCUL LAB
922	EMG
923	ADDITIONAL DX SVS
940	OTHER RX SVS
941	RECREATION RX
942	EDUC/TRAINING
943	CARDIAC REHAB
944	DRG REHABILITATION
946	CMPLX MED EQUIP-ROUT
947	CMPLX MED EQUIP
949	ADDITIONAL RX SVS
960	PROFESSIONAL FEES
961	PRO FEE/PSYCH
962	PRO FEE/EYE
963	PRO FEE/ANES MD
964	PRO FEE/ANES RN
965	RX PRESCRIPTION
969	OTHER PRO FEE
971	PRO FEE/LAB
972	PRO FEE/RAD DX
973	PRO FEE/RAD/RX
974	PRO FEE/NUC MED
975	PRO FEE/OR
976	PRO FEE/RESPIR
977	PRO FEE/PHYSI
978	PRO FEE/OCUPA
979	PRO FEE/SPEECH
981	PRO FEE/ER
982	PRO FEE/OUTPT
983	PRO FEE/CLINIC
984	PRO FEE/SOC SVC
985	PRO FEE/EKG
986	PRO FEE/EEG
987	PRO FEE/HOS VIS
988	PRO FEE/CONSULT
989	FEE/PVT NURSE
990	PT CONVIENCE
991	CAFETERIA
992	LINEN
993	TELEPHONE
994	TV/RADIO
995	NONPT ROOM RENT
996	LATE DISCHARGE
997	ADMIT KITS
998	BARBER/BEAUTY
999	TOTAL CHARGE

Claim Samples

UB92 Claim Form

Facility billing name and address | 2 | 3 PATIENT CONTROL NO. | TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV'D | 8 N-C D | 9 C-I D | 10 L-R D | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 DHR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

a b c d | 38 VALUE CODES CODE AMOUNT | 39 VALUE CODES CODE AMOUNT

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS/RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 CODE 70 CODE 72 CODE 74 CODE | 76 ADM. DIAG. CD. 304.00 | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | 83 OTHER PHYS. ID

84 REMARKS | OTHER PHYS. ID

1 | 2 | 3a PAT. CNTL # 3b MED. REC. # | 4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a b | 9 PATIENT ADDRESS a b c d e

10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | 18 19 20 21 | CONDITION CODES 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

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

PAGE ___ OF ___ CREATION DATE TOTALS

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. BNFT | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | 75 OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 76

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 b c d

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee L-6787-0297

UB-04 Claim Form Instructions

FORM LOCATOR NAME	INSTRUCTIONS
1. Billing Provider Name & Address	Enter the name and address of the hospital/facility submitting the claim.
2. Pay to Address	Pay to address if different than field 1.
3a. Patient Control Number	Enter your facility's unique account number assigned to the patient, up to 20 alpha/numeric characters. This number will be printed on the RA and will help you identify the patient.
3b. Medical Record Number	Number assigned to patient's medical record by provider. Up to 30 alpha/numeric characters.
4. Type of Bill	Enter the four digit code that identifies the specific type of bill and frequency of submission. The first digit is a leading zero. 2nd Digit - Submitting Facility 1 = Hospital 2 = Skilled Nursing 3 = Home Health 4 = Christian Science (Hospital) 5 = Christian Science (Extended Care) 6 = Intermediate Care 7 = Clinic (Use "2nd Digit - Clinics Only" below) 8 = Special Facility (Use "2nd Digit - Special Facilities Only" below) 2nd Digit - Bill Classification (*Except Clinics and Special Facilities*) 1 = Inpatient (Including Medicare Part A) 2 = Inpatient (Medicare Part B Only) 3 = Outpatient 4 = Other 5 = Intermediate Care - Level I

	6 = Intermediate Care - Level II 7 = Intermediate Care - Level III 8 = Swing Beds 2nd Digit - Clinics Only 1 = Rural Health 2 = Hospital Based or Independent Renal Dialysis Center 3 = Free Standing 4 = Outpatient Rehabilitation Facility (ORF) 5 = Comprehensive Outpatient Rehabilitation Facility (CORF) 9 = Other 2nd Digit - Special Facilities Only 1 = Hospice (Non-Hospital Based) 2 = Hospice (Hospital Based) 3 = Ambulatory Surgery Center 4 = Free Standing Birthing Center 9 = Other 3rd Digit - Frequency 0 = Non-Payment/Zero Claim 1 = Admit Through Discharge Date (one claim covers entire stay) 2 = First Interim Claim 3 = Continuing Interim Claim 4 = Last Interim Claim 5 = Late Charge(s) Only Claim 6 = 7 = Replacement of Prior Claim 8 = Void/Cancel of Prior Claim
5. Federal Tax Number	Enter the facility's tax identification number.

6. Statement Covers Period	Enter the beginning and ending service dates of for the period covered on the claim in MMDDYY format.
7. Administrative Necessary Days	Enter the number of Administratively Necessary Days (AND).
8. Patient Name	Enter the recipient's name exactly as it is spelled on the Medical Assistance ID card.
9. Patient Address	Enter the recipient's mailing address including street address, city, state and zip code.
10. Birth Date	Enter the recipient's date of birth in MMDDCCYY format.
11. Sex	Enter "M" for Male, "F" for Female or "U" for unknown.
12. Admission Date	Enter the start date of this episode of care. Use the MMDDCCYY format.
13. Admission Hour	Enter the hour (using a two-digit code below) that the patient entered the facility. 1:00 a.m. - 01 2:00 a.m. - 02 3:00 a.m. - 03 4:00 a.m. - 04 5:00 a.m. - 05 6:00 a.m. - 06 7:00 a.m. - 07 8:00 a.m. - 08 9:00 a.m. - 09 10:00 a.m. - 10 11:00 a.m. - 11 12:00 noon - 12 1:00 p.m. - 13 2:00 p.m. - 14 3:00 p.m. - 15 4:00 p.m. - 16 5:00 p.m. - 17 6:00 p.m. - 18 7:00 p.m. - 19 8:00 p.m. - 20 9:00 p.m. - 21 10:00 p.m. - 22 11:00 p.m. - 23 12:00 a.m. - 24/00

4.

14. Admit Type	Enter one of the following primary reason for admission codes: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information Not Available
15. Source of Admission	Enter one of the following source of admission codes: 1 = Physician Referral 2 = Clinic Referral 3 = HMO Referral 4 = Transfer from Hospital 5 = Transfer from SNF 6 = Transfer From Another Health Care Facility 7 = Emergency Room 8 = Court/Law Enforcement 9 = Information Not Available In the Case of Newborn 1 = Normal Delivery 2 = Premature Delivery 3 = Sick Baby 4 = Extramural Birth
16. Discharge Hour	Enter the hour (using a two-digit code below) that the patient entered the facility. 1:00 a.m. - 01 2:00 a.m. - 02 3:00 a.m. - 03 4:00 a.m. - 04 5:00 a.m. - 05 6:00 a.m. - 06 7:00 a.m. - 07 8:00 a.m. - 08 9:00 a.m. - 09 10:00 a.m. - 10 11:00 a.m. - 11 12:00 noon - 12

	1:00 p.m. - 13 2:00 p.m. - 14 3:00 p.m. - 15 4:00 p.m. - 16 5:00 p.m. - 17 6:00 p.m. - 18 7:00 p.m. - 19 8:00 p.m. - 20 9:00 p.m. - 21 10:00 p.m. - 22 11:00 p.m. - 23 12:00 a.m. - 24/00
17. Patient Discharge Status	Enter one of the following two-digit codes for the patient's status (as of the "through" date): 01 = Discharged to home or self care (routine discharge) 02 = Discharged/transferred to another short-term general hospital 03 = Discharged/transferred to skilled nursing facility (SNF) 04 = Discharged/transferred to an intermediate care facility (ICF) 05 = Discharged/transferred to another type of institution 06 = Discharged/transferred to home under care of organized home health service organization 07 = Left against medical advice 08 = Reserved 09 = Admitted as an inpatient to this hospital (Medicare Outpatient Only) 20 = Expired (or did not recover - Christian Science patient) 21 – 29 Reserved 30 = Still a patient 40 = Expired at home 41 = Expired in a medical facility; e.g., hospital, SNF, ICF, or free-standing hospice (Medicare Hospice Care Only) 42 = Expired - place unknown (Medicare Hospice Care Only) 43 = Discharged to Federal Health Care Facility

	50 = Hospice- Home 51 = Hospice – Medical Facility 52- 60 Reserved 61 = Discharge to Hospital Based Swing Bed 62 = Discharged to Inpatient Rehab 63 = Discharged to Long Term Care Hospital 64 = Discharged to Nursing Facility 65 = Discharged to Psychiatric Hospital 66 = Discharged to Critical Access Hospital
18-28. Condition Codes	Enter two digit alpha numeric codes up to eleven occurrences to identify conditions that may affect processing of this claim. See National Uniform Billing Committee for guidelines.
29. Accident State	Enter two-digit state abbreviation.
30. Accident Date	Date accident occurred.
31-34. Occurrence Codes and Dates	Enter up to four code(s) and associated date(s) for any significant event(s) that may affect processing of this claim. 01 = Auto Accident 02 = Auto Accident - No Fault Insurance 03 = Accident - Tort Liability 04 = Accident - Employment Related 05 = Other Accident 06 = Crime Victim 09 = Start of Infertility Treatment 11 = Illness - Onset of Symptoms 12 = Date of Onset For Chronically Dependant 16 = Date of Last Therapy 17 = Date Outpatient Occupational Therapy 18 = Date of Retirement 20 = Date Guarantee of Payment Began

	21 = Date UR Notice Received 22 = Date Active Care Ended 24 = Date Insurance Denied 25 = Date Benefits Terminated By Primary Payer 26 = Date Skilled SNF Became Available 27 = Date Hospice Certification 28 = Date Comprehensive Outpatient Rehab 29 = Date Outpatient Physical Therapy 30 = Date Outpatient Speech Pathology 31 = Date Beneficiary Notified of Intent to Bill (procedures) 32 = Date Beneficiary Notified of Intent to Bill 33 = First Day of COB for ESRD 34 = Date of Election of Extended Care 35 = Date Treatment for Physical Therapy 36 = Date of Inpatient Discharge for Covered Transplant 37 = Date of Inpatient for Non-Covered Transplant 38 = Date Treatment for Home IV 39 = Date Discharged on Continuous IV 40 = Scheduled Date of Admission 41 = Date of First Test Pre-Admit 42 = Date of Discharge 43 = Cancelled Surgery 44 = Inpatient Admit Changed to Outpatient 44 = Date Treatment Started Occupational 45 = Date Treatment Started Speech 46 = Date Treatment Started Cardiac Rehab 47 = Date Cost Outlier Begins A1= Birth Date- Insured A A2 = Effective Date – Insured A Policy A3 = Benefits Exhausted A4 = Split Bill Date

	B1= Birth Date-Insured B B2 = Effective Date Policy B B3 = Benefits Exhausted – Payer B C1 = Birth Date – Insured C C2 = Effective Date – Insured C C3 = Benefits Exhausted -Payer C
35-36. Occurrence Span	Enter the span of occurrence dates as indicated in 31 - 35.
38. Responsible Party Name and Address	Enter the responsible party name and address.
39. - 41. Value Code and Amount	Enter up to three value codes to identify special circumstances that may affect processing of this claim. See NUBC manual for specific codes. In the Amount box, enter the number, amount, or UCR value associated with that code.
42. Revenue Code	Enter a four digit Revenue Code beside each service described in column 43. (See Section 800, "Revenue Codes.") After the last Revenue Code, enter "0001" corresponding with the Total Charges amount in column 47. (PAPER CLAIMS ONLY)
43. Description	Enter a brief description that corresponds to the Revenue Code in column 42. List applicable NDC if location 44 is a J code. Report the N4 qualifier in the first two (2) positions, left justified, followed immediately by the 11 character NDC number. Immediately following the last character of the NDC (no space) the Unit of Measurement Qualifier immediately followed by the quantity with a floating decimal with a limit of 3 characters to the right of the decimal point. Unit of Measurement: F2 - International Unit GR - Gram ML - Milliliter UN - Unit To report more than one NDC per HCPC use the

	NDC attachment form. Enter "Total Charges" after the last description in this column to correspond with the total of all charges amount in column 47.
44. HCPC	Utilized for outpatient bills. If billing for an injectable code must display an NDC in location 43.
45. Service Date	Enter the date this service was provided (MMDDCCYY format).
46. Service Units	Enter the number of hospital accommodation days or units of service (such as pints of blood) which were rendered. AND days must correspond to the number of days in form locator 7.
47. Total Charges	Enter the total amount charged for each line of service. Also, enter the total of all charges after the last amount in this column.
48. Non-Covered Charges	Enter the amount, if any that is not covered by the primary payer for this service.
50. Payer	Enter the name and three-digit carrier code of the primary payer on line A and other payers on lines B and C. (Medical Assistance is always the payer of last resort.) **If the patient has Medical Assistance only, enter "RI Medicaid" on line A.** If Medicare is the primary payer, indicate Part A or Part B coverage.
51. Health Plan ID	The number used by the health plan to identify itself.
52. Release of Information	Enter "Y" for yes or "N" for no.
53. Assignment of Benefits	Enter "Y" for yes.
54. Prior Payments	Enter the amounts paid by the other insurance payers listed in form locator 50. If payment is made by other insurance, proof of payment (e.g., EOB) must be attached to the claim form.
55. Estimated Amount Due	The amount estimated to be due.

56. National Provider Identifier Billing Provider (NPI)	Unique identifier assigned to the provider. Seven digit RI Medical Assistance Provider ID if not submitting NPI.
57. Other Provider Identifier	**Taxonomy must be entered if NPI is entered in location 56**. This id **must** be entered in line A,B,C that corresponds to the line in which the "RI Medicaid" payer information is entered in locator 50.
58. Insured's Name	If other health insurance is involved, enter the insured's name.
59. Patient's Relation to Insured	Enter the code for the patient's relationship to the insured. 01 = Spouse 18 = Self 19= Child 20 = Employee 21 = Unknown 39 = Organ Donor 40 = Cadaver Donor 53 = Life Partner G8 = Other Relationship
60. Insured's Unique Identifier	Enter recipient's nine-digit Medical Assistance ID. This id **must** be entered in line A,B,C that corresponds to the line in which the RI Medicaid payer information is entered in locator 50.
61. Group Name	Enter the name of insured's other group health coverage, if applicable.
62. Insurance Group Number	Enter insured's group number, if applicable.
63. Treatment Authorization Number	Number that designates that treatment has been authorized.
64. Document Control Number	Control number assigned to the original bill.

INPATIENT

1 Any Hospital, 123 Any Street, Philadelphia PA 19103
2 Any Hospital, 456 Any Street, Philadelphia PA 19103
3a PAT. CNTL # 1234
3b MED. REC. # 98765
4 TYPE OF BILL 0111
5 FED. TAX NO. 221234567
6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06
7 RESERVED

8 PATIENT NAME: a Patient ID if different from Sub
9 PATIENT ADDRESS: a 1234 Main Street
b Doe, John
b Philadelphia c PA d 19111 Country code if other than USA

10 BIRTH DATE 03 20 1971 | 11 SEX M | 12 ADMISSION DATE 11 03 06 | 13 HR 08 | 14 TYPE 3 | 15 SRC 3 | 16 DHR 12 | 17 ST AT 01 | 18 19 20 21 CONDITION CODES Condition Codes Required Identifying Events | 22 23 24 25 26 27 28 | 29 ACCT STATE PA | 30 RESERVED

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE FROM THROUGH | 36 OCCURRENCE CODE FROM THROUGH | 37 FUTURE USE

Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing

38 John Doe, 1234 Main Street, Philadelphia, PA 19111

39 VALUE CODES AMOUNT | 40 VALUE CODES AMOUNT | 41 VALUE CODES AMOUNT
a A1 952:00
b Value Codes and amounts required when necessary to process claim
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
0129	Semi-Private	200.00		2	400:00	0:00	Future Use
0250	Pharmacy			1	50:00	0:00	
0360	OR Services				100:00	0:00	

50 PAYER NAME: a Independence Blue Cross, b Secondary Payer, c Tertiary Payer
51 HEALTH PLAN ID: Report HIPAA National Health Plan Identifier when mandatory
52 REL. INFO. Y; 53 ASG. BEN. Y
54 PRIOR PAYMENTS: Required when indicated payer has paid amount to Provider
55 EST. AMOUNT DUE: Amount estimated to be due
56 NPI 2222222222
57 OTHER PRV ID 1234567890 Secondary Tertiary

58 INSURED'S NAME: a Doe, John, b Secondary, c Tertiary
59 P. REL 18
60 INSURED'S UNIQUE ID ABC1234567800
61 GROUP NAME Watch Repair, Inc.
62 INSURANCE GROUP NO. 1234

63 TREATMENT AUTHORIZATION CODES: a 02468, b Secondary, c Tertiary
64 DOCUMENT CONTR OL NUMBER 491234
65 EMPLOYER NAME Watch Repair, Inc.

66 DX 3910 Use A through Q to report "Other Diagnosis" if applicable 68 Reserved
67 Q
67 A 4280 | 70 PATIENT REASON DX May be used to report reason for visit | 71 PPS CODE DRG | 72 ECI May be used to report external cause of injury | 73 Reserved
74 PRINCIPAL PROCEDURE CODE DATE 3749 11 03 06 | b. OTHER PROCEDURE CODE DATE | 75 Reserved | c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 2222222222 QUAL 1G 1234569822 LAST Smith FIRST David
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: May be used to report additional information.
81 CC a B3 282N00000X; b Secondary; c Tertiary; d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

3 12.09

Red = Required
Black = Situational/Required, if applicable/Reserved

Independence Blue Cross
www.ibx.com

OUTPATIENT

1 Any Hospital, 123 Any Street, Philadelphia PA 19103
2 Any Hospital, 456 Any Street, Philadelphia PA 19103
3a PAT. CNTL # 1234
3b MED. REC. # 98765
4 TYPE OF BILL 0131
5 FED. TAX NO. 221234567
6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06
7 RESERVED

8 PATIENT NAME: a Patient ID if different from Sub
9 PATIENT ADDRESS: a 1234 Main Street
b Doe, John
b Philadelphia c PA d 19111 Country code if other than USA

10 BIRTH DATE 03 20 1971 | 11 SEX M | 12 ADMISSION DATE 11 03 06 | 13 HR 08 | 14 TYPE 3 | 15 SRC 3 | 16 DHR 12 | 17 ST AT 01 | 18 19 20 21 CONDITION CODES Condition Codes Required Identifying Events | 22 23 24 25 26 27 28 | 29 ACCT STATE PA | 30 RESERVED

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE FROM THROUGH | 36 OCCURRENCE CODE FROM THROUGH | 37 FUTURE USE

Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing

38 John Doe, 1234 Main Street, Philadelphia, PA 19111

39 VALUE CODES AMOUNT | 40 VALUE CODES AMOUNT | 41 VALUE CODES AMOUNT
a A1 952:00
b Value Codes and amounts required when necessary to process claim
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
0310	Laboratory N400093723106	88173	11 03 06	1	100:00	0:00	Future Use
0402	Ultrasoud	76942	11 04 06	1	100:00	0:00	
0360	OR Services	3749	11 04 06	1	100:00	0:00	

PAGE 1 OF 1 CREATION DATE TOTALS 300:00 0:00

50 PAYER NAME: a Independence Blue Cross, b Secondary Payer, c Tertiary Payer
51 HEALTH PLAN ID: Report HIPAA National Health Plan Identifier when mandatory
52 REL. INFO. Y; 53 ASG. BEN. Y
54 PRIOR PAYMENTS: Required when indicated payer has paid amount to Provider
55 EST. AMOUNT DUE: Amount estimated to be due
56 NPI 2222222222
57 OTHER PRV ID 1234567890 Secondary Tertiary

58 INSURED'S NAME: a Doe, John, b Secondary, c Tertiary
59 P. REL 18
60 INSURED'S UNIQUE ID ABC1234567800
61 GROUP NAME Watch Repair, Inc.
62 INSURANCE GROUP NO. 1234

63 TREATMENT AUTHORIZATION CODES: a 02468, b Secondary, c Tertiary
64 DOCUMENT CONTR OL NUMBER 491234
65 EMPLOYER NAME Watch Repair, Inc.

66 DX 3910 Use A through Q to report "Other Diagnosis" if applicable 68 Reserved
67 Q
67 A 4280 | 70 PATIENT REASON DX May be used to report reason for visit | 71 PPS CODE DRG | 72 ECI May be used to report external cause of injury | 73 Reserved
74 PRINCIPAL PROCEDURE CODE DATE 3749 11 04 06 | b. OTHER PROCEDURE CODE DATE | 75 Reserved | c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 2222222222 QUAL 1G 1234569822 LAST Smith FIRST David
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS: May be used to report additional information.
81 CC a B3 282N00000X; b Secondary; c Tertiary; d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

4 12.09

Red = Required
Black = Situational/Required, if applicable/Reserved

Independence Blue Cross
www.ibx.com

65. Employer Name	Name of employer providing health coverage.
66. Diagnosis and Procedure Code Qualifier	Enter 9 for ICD 9 coding.
67. Principal Diagnosis Code on Admission	Enter the ICD-9-CM diagnosis code that describes the nature of the illness or injury.
67A - Q Other Diagnosis Codes	Enter up to 16 ICD-9-CM codes for other diagnoses.
68. Admitting Diagnosis Code	Enter the ICD-9-CM diagnosis code that describes the patient's condition at the time of admission.
70. Patient's Reason for Visit	Enter the ICD-9-CM diagnosis code that describes the patient's reason for visit.
71. PPS Code	The PPS code assigned to the claim.
72. External Cause of Injury Code	Enter the ICD-9-CM diagnosis code pertaining to external cause of injuries.
74. Principal Procedure Code and Date	Enter the ICD code that identifies the principal procedure performed. Enter the date of that procedure.
74A-E. Other Procedure Codes	Enter other ICD codes identifying all significant procedures performed. Enter the date of those procedures.
76. Attending Provider Name and Identifiers	Enter NPI of individual in charge of patient care. If UPIN number is entered, qualifier must be 1G. Enter the last and first name below.
77. Operating Physician Name and Identifiers	Required when surgical procedure is performed. Enter the NPI. If UPIN number is entered, qualifier must be 1G. Enter the last and first name.
78. - 79. Other Provider Name and Identifiers	Enter the NPI. If UPIN number is entered, qualifier must be 1G. Enter the last and first name.
80. Remarks Field/**Signature**	**Enter provider signature or authorized agent.**

81cc. Code-Code Field	Enter B3 in the qualifier if locations 76-79 contain an NPI. **Enter the corresponding provider taxonomy of provider NPI's entered in locations** 76a – 81CCa 77b – 81CCb 78c – 81CCc 79d – 81CCd

APPROVED OMB-0938-0008

-A-

HCFA 1500 Sample Form

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) **B**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS Single Married Other
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
Employed Full-Time Student Part-Time Student
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 **C**
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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 **D** 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 **E**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY **F**
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. ___ . __ 3. ___ . __
2. ___ . __ 4. ___ . __
22. MEDICAID 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3		**G**								
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO. **H**
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO **I**
28. TOTAL CHARGE $ **J**
29. AMOUNT PAID $
30. BALANCE DUE $
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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

(1500)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS Single Married Other
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
Employed Full-Time Student Part-Time Student
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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 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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ___ . ___ 3. ___ . ___
2. ___ . ___ 4. ___ . ___
22. MEDICAID 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								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
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. b.
33. BILLING PROVIDER INFO & PH # ( ) a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

SAMPLE

Medicare Claims Processing Manual

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

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(Rev. 1552, 07-18-08)
(Rev. 1638, 11-20-08)

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10 - Health Insurance Claim Form CMS-1500

(Rev. 1058, Issued: 09-15-06; Effective: 01-01-07, Implementation: 01-02-07)

The Form CMS-1500 (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance suppliers), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc. To purchase them from the U.S. Government Printing Office, call (202) 512-1800.

There are currently two versions of the Form CMS-1500. The current approved version of the form as of 2005 is the Form CMS-1500 (12/90). The current version is approved under the Office of Management and Budget (OMB) collection 0938-0008. The revised version of the form is Form CMS-1500 (08/05) and is approved under the OMB collection 0938-0999. The current claim form was revised to accommodate the implementation of the National Provider Identifier (NPI), which is scheduled for completion of the implementation in May 2007.

Between January 1, 2007, and March 31, 2007, either version of the Form CMS-1500 will be accepted by Medicare contractors. Therefore, you will find information within this chapter that applies to both claim forms. The differences between the two forms will be noted within the body of the text that describes each of the items/boxes/fields of the Form CMS-1500. In addition to the text within the chapter, there are two exhibits at the end of this chapter that provide the print file specifications for each form. Exhibit 1 is the print file specification layout for the current Form CMS-1500 (12-90) and Exhibit 2 is the print file specification layout for the Form CMS-1500 (08-05).

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers. It has also been adopted by the TRICARE Program and has received the approval of the American Medical Association (AMA) Council on Medical Services.

There are a number of Part B services that have special limitations on payments or that require special methods of benefit computation. Carriers should monitor their processing systems to insure that they recognize the procedure codes that involve services with special payment limitations or calculation requirements. They should be able to identify separately billed procedure codes for physician services which are actually part of a global procedure code to prevent a greater payment than if the procedure were billed globally.

The following instructions must be completed or are required for a Medicare claim. Carriers should provide information on completing the Form CMS-1500 to all physicians and suppliers in their area at least once a year.

Providers may use these instructions to complete this form. The Form CMS-1500 has space for physicians and suppliers to provide information on other health insurance. This information can be used by carriers to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is another insurer to which Medicare can forward billing and payment data following adjudication if the provider is a physician or supplier that participates in Medicare. (See Pub 100-05, Medicare Secondary Payer Manual, Chapter 3, and Chapter 28 of this manual).

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Legend	Description
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position Year (e.g., 1998 = 98)
CCYY	4 position Year (e.g., 1998 = 1998)
(MM | DD | YY) or (MM | DD | CCYY)	A space must be reported between month, day, and year (e.g., 12 | 15 | 98 or 12 | 15 | 1998). This space is delineated by a dotted vertical line on the Form CMS-1500)
(MMDDYY) or (MMDDCCYY)	No space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

10.1 – Claims That are Incomplete or Contain Invalid Information

(Rev. 145, 04-23-04)

If a claim is submitted with incomplete or invalid information, it may be returned to the submitter as unprocessable. See Chapter 1 for definitions and instructions concerning the handling of incomplete or invalid claims.

10.2 - Items 1-11 - Patient and Insured Information

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

Item 1 - Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a - Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. This is a required field.

Item 2 - Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. This is a required field.

Item 3 - Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Item 4 - If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5 - Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6 - Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7 - Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.

Item 8 - Check the appropriate box for the patient's marital status and whether employed or a student.

Item 9 - Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. **This field may be used in the future for supplemental insurance plans.**

NOTE: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the *b*eneficiary wishes to assign his/her benefits under a MEDIGAP policy to the participating physician or supplier..

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. (See chapter 28.)

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a - Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed, even when the provider enters a policy and/or group number in item 9a.

Item 9b - Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

Item 9c - Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, MD 21204

is shown as "1257 Anywhere St. MD 21204."

Item 9d - Enter the 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer through the Medigap claim-based crossover process, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d.

A Medicare participating provider or supplier shall **only** enter the COBA Medigap claim-based ID within item 9d when seeking to have the beneficiary's claim crossed over to a Medigap insurer. If a participating provider or supplier enters the PAYERID or the Medigap insurer program or its plan name within item 9d, the Medicare Part B contractor or Durable Medical Equipment Medicare Administrative Contractor (DMAC) will be unable to forward the claim information to the Medigap insurer prior to October 1, 2007, or to the Coordination of Benefits Contractor (COBC) for transfer to the Medicare insurer on or after October 1, 2007. (See chapter 28 §70.6.4 for more information concerning the COBA Medigap claim-based crossover process.)

Items 10a through 10c - Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d - Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

Item 11 - THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "None" in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to Medicare - Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
  - Working Aged;
  - Disability (Large Group Health Plan); and
  - End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
  - Workers' Compensation;
  - Black Lung; and
  - Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3.)

10.3 - Items 11a - 13 - Patient and Insured Information

(Rev. 1369; Issued: 11-02-07; Effective: 04-01-08; Implementation: 04-07-08)

Item 11a - Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item 11b - Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."

Item 11c - Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d - Leave blank. Not required by Medicare.

Item 12 - The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements." If the patient is physically or mentally unable to sign, a representative specified in Chapter 1, "General Billing Requirements" may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

NOTE: This can be "Signature on File" and/or a computer generated signature.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

NOTE: This can be "Signature on File" signature and/or a computer generated signature.

10.4 - Items 14-33 - Provider of Service or Supplier Information

(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

Item 17a – Enter the ID qualifier 1G, followed by the CMS assigned UPIN of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24J of this section.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the NPI/PIN of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number (or NPI) of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F - Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

NOTE: This field should contain at least 1day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H - Leave blank. Not required by Medicare.

Item 24I - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.

Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;

- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 - Enter the name and address, and ZIP Code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and ZIP Code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP Code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP Code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP Code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

Item 32b - If required by Medicare claims processing policy, enter the PIN of the service facility. Be sure to precede the PIN with the ID qualifier of 1C. There should be one blank space between the qualifier and the PIN.

NOTE: Effective May 23, 2008, Item 32b is not to be reported.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number. This is a required field.

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Suppliers billing the DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.

Telephone

Telephone User Guide
For the Elite IPK

All phones are speakerphones. To use the speakerphone, ensure the MIC is lit (this enables the caller to hear you).
Using the Speakerphone - Press Speaker
Dial the number you are calling
Begin the conversation
Muting the Speakerphone – Press **Mic Button (Mic. light goes out)**

Volume Adjustment

Ringing Volume
Press **Speaker**
Dial **601**
Adjust ringing volume using the up and down arrows on the side of phone.
Press Speaker to set

Off hook ringing
Lift handset
Dial **601**
Adjust ringing volume using the up and down arrows on the side of phone.
Hang-up to Set

Audible Volume
While on speaker or with handset lifted using the up and down arrows also adjust what you are hearing.

Contrast Adjustment
While your phone is idle, you may adjust the contrast in the display by using the up and down arrows.

Answering Incoming Calls

Ringing Phone
Lift handset – You are connected to the outside call.

Note: When a call comes into your Direct Number or is transferred to your extension that call will ring to one of the buttons labeled with your extension number

Holding Calls

With a caller on the line
Press **Red Hold Button**
Hang Up

Retrieving Held Calls

Press flashing extension key

"607" ext #

Call Pickup Direct

Definition: Allows you to answer a specific ringing extension
Lift Handset
Press **Pick Up** Button
Dial the **Extension Number**

Transferring Calls

With a call in progress
Press **Transfer** (Which automatically puts caller on hold)
Dial **Ext. Number**
Wait for answer to announce call
Or
Dial **7 to Transfer a call directly to voicemail**

Placing Outgoing Calls

Lift handset **or** press Speaker (Ensure Mic. is lit if using the speaker)
Dial **9**
Dial **Telephone Number**
Note: When placing out going calls those call will be on one of the buttons labeled with your extension number

Placing Internal Calls

Lift handset /Speaker (You are hearing internal dial tone)
Dial **Ext. Number** –Wait for Answer.
Note 1: By pressing **1** you may toggle between voice and ringing.
Note 2: If no answer dial **7**, this takes you directly to their voice mail, enabling a voice mail message to be left

Paging

All Page – Press Page Button or Dial 51
UR – Dial 52
Claims – Dial 53
IW – Dial 54

Automatic Callback

Definition: Notifies you when an extension is no longer busy.
Lift handset/speaker
Dial **Extension** (Receive busy signal)
Press **0**
Hang Up
When the busy extension hangs up, your phone will ring, once you answer you are automatically connected to the ext.
The system waits until both handsets are idle before initiating the callback.

Last Number Redial (System remembers the last number dialed from your phone).

Press **Redial** and *

Conference Calling (Three way calling)

With a call in progress
Press **Conf.**
Place a second call (either an ext. or dial outside number)
Press **Conf.**
Note 1: You are limited to 2 outside callers
Note 2: Unsupervised Conference - allows you to set up the conference and hang-up leaving the 2 callers connected. Press CONF. and hang-up. To reenter the conference, press the flashing Conf. key

Programming Personal Speed Dial Numbers (20 Numbers Available)

Leave handset down
Press **Feature** - Press **Redial**
Dial memory location code **80 through 99** (these are your 20 codes)
Dial **9**
Dial **Telephone Number**
Press **Hold** (Enter Name of dialed party) (Max. of 13 letters) - **(Display Phones)**
Press **Feature**
Note: As you enter names the system alphabetizes them for you.
*Using the touch tone pad continue pressing the button until the character you wish appears in the screen.
If you wish to use the same button for a different character you must press the # key enabling you to continue.
The ## key also is used for a space.
If you make a mistake press **Conf. to backspace**.

Calling a Speed Dial Number

Press the **Gray** (Soft Key) under **STA** in the display
Use the **Gray Buttons** under **Up and Down** until the name is displayed you wish to call.
Lift handset or **press speaker**
The system picks up a line and dials the number for you.
Or
Press **Redial**
Press the **two-digit Speed Dial Code**

Programming Spare Feature Key for Speed Dialing

Leave Handset Down
Press **Feature**
Press **Redial**
Press **Button** to Program
Dial **1 and Enter Extension Number**
Or
Dial **0 + 9 + Telephone Number**
Press **Feature**

Call Forward All Calls

Press **Feature**
Dial **60**
Dial **Ext. #** you wish to forward to
Press **Feature**

Do Not Disturb - Set

Press **Feature**
Dial **60**
Press **Feature**

Call Forward All Call & Do Not Disturb – Cancel

Press **Feature**
Dial **69**
Press **Feature**

SHP / ACH
Groups

CorrectCare
INTEGRATED HEALTH

SOUTHERN HEALTH PARTNERS

JAIL	NAME	
1	Adair County Regional Jail	5/1/08
9	Bourbon County	
10	Boyd County Detention Center-	11/1/08
15	Bullitt County	
19	Campbell County-	Staffing only 2/1/09
22	Carter County	
29	Crittenden County	
30	Daviess County	
37	Franklin County	
41	Grant County	
47	Hardin County	-State Inmates Only
50	Hart County	
51	Henderson County	
54	Hopkins County	
59	Kenton County	7/1/08
62	Larue County Jail	2/15/09
73	McCracken County	7/15/08
78	Marion County Jail	To start 4/1/09
87	Montgomery County Jail	1/1/09
93	Oldham County	
100	Pulaski County	
105	Scott County Detention Center	7/1/08
106	Shelby County	
107	Simpson County	
109	Taylor County Jail-Claims returned to jail.	
114	Warren County	
120	Woodford County	

ADVANCED CORRECTIONAL HEALTHCARE

JAIL	NAME	
4	Ballard County Jail	3-20-08
23	Casey County Jail	1-4-07
38	Fulton County Detention Center	
42	Graves County Jail	
53	Hickman County Jail	
60	Knott County	End 3/27/08
65	Three Forks Regional Jail	5/21/08

CorrectCare
INTEGRATED HEALTH

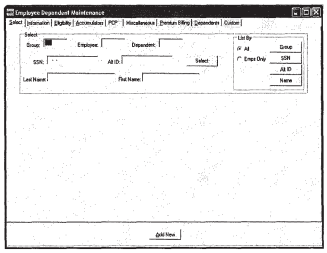
71	Logan County	
97	Perry County	End 3/27/08
99	Powell County	
103	Rowan County Detention Center	8/28/08
117	Webster County Detention Center	

WLT Eligibility

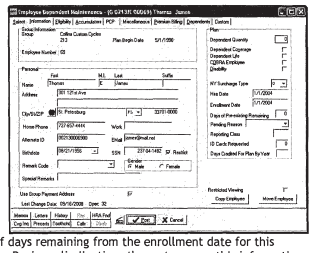
Employee/Dependent Maintenance

This option allows you to add new employees and dependents, and to view and change existing employees and dependents. The **Select** tab is displayed the program is accessed.

Information



Here you can update the employee's name and address information, hire date, New York Region Code, and other static information.



Alternate ID - When adding a new employee, this field will default to a GGGGGEEEEEDD format, where GGGGG is the zero-filled group number, EEEEE is the zero-filled employee number, and DD is the zero-filled dependent number. However, you can use this field to establish alternate IDs in any format you wish, up to 20 alphanumeric characters.

Use Group Payment Address- Select this option to have claim payments payable to the employee sent to an employer group address (defined in **Group Maintenance > Accounts**).

Days of Pre-existing Remaining - The number of days remaining from the enrollment date for this employee's pre-existing condition provision. During adjudication, the system uses this information to determine whether the claim is incurred within the preexisting time frame. The number of days is automatically calculated based on the group's **Pre-Existing Months to Check** and the employee's **Enrollment Date**. It can be overridden to reduce the number of days for HIPAA prior coverage credit.

Pending Reason - You can select a pending reason to be attached to the employee. All claims processed for the employee will then be pended with the selected pend code. This pend code will overwrite any codes set by the editor. For example, if the claim would have been pended for errors (code 20) and the employee has an override pend code for Red Flagged Employee (code 34) the editor will set the pend reason as red flagged employee. (If you want to pend claims for all family members, you will need to set a pend reason on each of the dependents as well.)

Restricted Viewing—Select this option to restrict viewing of this employee based on the security flag defined in Operator Maintenance.

Copy Employee - This button allows you to copy the employee's name, address, effective dates, and dependents from one group to another, leaving the original employee record intact so that the employee is in both groups. It does not copy the employee's history from the old group to the new

Miscellaneous

CorrectCare
INTEGRATED HEALTH

DATE_____

CLAIM_____

PROCESSOR_____

☐ Does not count as an error.

ERROR TYPE

____Eligibility

____Incorrect Authorization entered

____No authorization on file

____Incorrect Inmate

____Incorrect Provider

____Claim paying to enrollee

___Other

_____

_____

_____

_____

_____

_____

Date Corrected_____

By:_____

Date released from hold_____

CorrectCare
INTEGRATED HEALTH

Group_____ Amount_____

REFUND

Date processed:	
Group:	
Inmate Name:	
Inmate ID:	
Claim Number:	
Date of Service:	
Reason for Refund:	
Amount of Refund:	
Original Check & Date	
Refund Check #	
Batch Debit WLT:	
Fund Deposit done	
Deposit not done in WLT	

CorrectCare
INTEGRATED HEALTH

CLAIM PROBLEM LOG

INMATE NAME_____

ID NUMBER_____

NEED ELIGIBILITY_____

NEED AUTHORIZATION_____

DATE SENT	DATE OF SERVICE	ISSUE OR PROBLEM WITH AUTHORIZATON

ELIGIBILITY LOCATION_____ **DATES**_____

AUTHORIZATION NUMBER_____

DATE COMPLETED_____ **BY** _____

CorrectCare
INTEGRATED HEALTH

ADJUSTMENT/CLAIM REVIEW FORM

DATE_____

CLAIM_____

REQUEST TYPE

____ADJUSTMENT REQUIRED

____NETWORK ALLOW AMOUNT REVIEW

____PROCESS CLAIM

____OTHER

ISSUE/PROBLEM

_____

_____

_____

_____

_____

RESPONSE/ADDITIONAL INFORMATION

_____

_____

_____

COMPLETED_____

DATE COMPLETED_____

BY:_____

CorrectCare
INTEGRATED HEALTH

Thank you for your claim submission to CorrectCare Integrated Health, the enclosed claim is being returned for the reasons indicated below.

_____Claim does not have Jail claim form attached showing jail location.

_____Patient was not a state or county inmate on date of service.

_____Claim not submitted on a standard HCFA 1500/UB92 form.

_____Claim submitted with no charge amounts.

_____Claim submitted with no date of service.

_____Claim submitted with no diagnosis code or invalid code.

_____Claim submitted with no procedure code or invalid code.

_____Physicians Tax ID number not entered in box 25 on HCFA 1500

_____Physicians name not entered in box 33 on HCFA 1500

_____Physicians/Suppliers name and address not entered in box 33 on HCFA 1500

_____Other_____

_____

_____

Please return the indicated information along with the claim to ensure timely processing. Thank you in advance for your assistance in this manner. If you have questions concerning this information, please contact us at (859) 225-7999 or (877) 292-7999

Sincerely,

CorrectCare Integrated Health
Claims Department

441.045 Rules for jails -- Inspection by county judge/executive -- Medical, dental, and psychological care for prisoners -- Funds not to lapse.

(1) The county governing body shall prescribe rules for the government, security, safety, and cleanliness of the jail and the comfort and treatment of prisoners, provided such rules are consistent with state law. The county judge/executive may inspect the jail at any reasonable time.

(2) Willful violation of the rules promulgated pursuant to subsection (1) of this section shall be deemed a violation.

(3) Except as provided in subsections (4) and (5) of this section, the cost of providing necessary medical, dental, and psychological care for indigent prisoners in the jail shall be paid from the jail budget.

(4) The cost of providing necessary medical, dental, or psychological care for prisoners of the United States government shall be paid as provided by contract between the United States government and the county or as may otherwise be provided by federal law.

(5) The cost of providing necessary medical, dental, or psychological care, beyond routine care and diagnostic services, for prisoners held pursuant to a contractual agreement with the state shall be paid as provided by contract between the state and county. The costs of necessary medical, dental, or psychological care, beyond routine care and diagnostic services, of prisoners held in the jail for which the county receives a per diem payment shall be paid by the state.

(6) The cost of providing necessary medical, dental, or psychological care for prisoners held pursuant to a contractual agreement with another county or a city shall be paid as provided by contract between the county or city and county.

(7) When the cost of necessary medical, dental, or psychological care for a prisoner exceeds two thousand dollars ($2,000), as calculated by using the maximum allowable costs to similar persons or facilities for the same or similar services under the Kentucky Medical Assistance Program, the state shall reimburse the county for that portion of the costs that exceeds two thousand dollars ($2,000). The reimbursement shall be subject to the following terms and conditions:

(a) The care is necessary as defined in subsection (10) of this section;

(b) The prisoner is indigent as defined in subsection (8) of this section, or is uninsured; and

(c) No state reimbursement to the county for care provided by physicians, hospitals, laboratories, or other health care providers shall exceed the maximum payments allowed to similar persons or facilities for the same or similar services under the Kentucky Medical Assistance Program, except as provided in subsection (11) of this section.

(8) (a) The determination of whether a prisoner is indigent shall be made pursuant to KRS 31.120. The prisoner shall not be considered indigent, in the case of prisoner medical care, if:

1. The prisoner has funds on his inmate account to cover all or a portion of his medical expenses;

2. The prisoner's medical expenses are covered on a medical insurance policy; or

3. The prisoner has the private resources to pay for the use of the medical facilities.

(b) Prisoners who are later determined not to have been indigent, or who at a time following treatment are no longer indigent, shall be required to repay the costs of payments made pursuant to this section to the unit of government which made the payment.

(9) The terms and conditions relating to any determination of nonindigency and demands for repayment shall be under the same terms and conditions as are provided under KRS Chapters 31 and 431 relating to similar circumstances in the program for defense of indigents by the public advocate.

(10) For the purposes of this section, "necessary care" means care of a nonelective nature that cannot be postponed until after the period of confinement without hazard to the life or health of the prisoner. The physician attending the prisoner shall certify, under oath, that the care was necessary.

(11) Any money appropriated for a given fiscal year to fund the state's obligation under subsection (7) of this section which remains unspent at the end of the year shall not lapse but shall be made available to satisfy, to the maximum extent possible, that portion of each catastrophic claim made during said year above the threshold amount for which the county did not receive state assistance pursuant to subsection (7) of this section. In the event there is an insufficient surplus to satisfy said balance of all such catastrophic claims which are made during that year, the state shall pay to those qualified counties, on a per claim basis, an amount equal to each claim's percentage of the total surplus. Should the surplus be sufficient to satisfy all such catastrophic claims, the amount remaining, if any, shall not lapse but shall be carried forward to the next fiscal year to be made available for future catastrophic claims.

(12) Notwithstanding other provisions of this section to the contrary, a jail may impose a reasonable fee for the use of jail medical facilities by a prisoner who has the ability to pay for the medical care. These funds may be deducted from the prisoner's inmate account. A prisoner shall not be denied medical treatment because he has insufficient funds on his inmate account. This subsection shall not preclude other recovery of funds as provided in this section.

Effective: July 15, 1996

History: Amended 1996 Ky. Acts ch. 61, sec. 1, effective July 15, 1996; and ch. 108, sec. 2, effective July 15, 1996. -- Amended 1986 Ky. Acts ch. 343, sec. 1, effective July 15, 1986. -- Amended 1984 Ky. Acts ch. 415, sec. 2, effective July 13, 1984. -- Amended 1982 Ky. Acts ch. 385, sec. 38, effective July 1, 1982. -- Amended 1979 (1st Extra. Sess.) Ky. Acts ch. 21, sec. 1, effective May 12, 1979. -- Amended 1976 (1st Extra. Sess.) Ky. Acts ch. 12, sec. 2, effective January 1, 1978; and ch. 14, sec. 457, effective January 2, 1978. -- Recodified 1942 Ky. Acts ch. 208, sec. 1, effective October 1, 1942, from Ky. Stat. sec. 2233, 2235.

Formerly codified as KRS 441.010.

Legislative Research Commission Note (7/15/96). This section was amended by 1996 Ky. Acts chs. 61 and 108 which do not appear to be in conflict and have been codified together.