Physician Services/Plan Providers

CLAIM FORM REQUIREMENTS

When billing for services, please pay attention to the following points:

- Submit claims on a current CMS 1500 or UB04 form.
  Please include the following information:

1. Patient name (CMS Box 2/UB04 Box 8a)
2. Patient DOB (CMS Box 3/UB04 Box 10)
3. Patient 11-digit member number (CMS Box 1a/ UB04 Box 60)
4. Provider’s 10-digit National Provider Identifier (NPI) number

**CMS 1500:**
  a) Referring Provider NPI in Box 17B
  b) Rendering Provider NPI in Box 24J
  c) Service Facility Location Type II NPI in Box 32a
  d) Billing Provider Type II in Box 33a

**UB04:**
  a) Institution/Facility Type II NPI in Box 56
  b) Attending Physician NPI in Box 76
  c) Operating Physician NPI in Box 77

5. ICD-10 diagnosis code and description (CMS Box 21/UB04 Box 66)
6. Date of service (CMS Box 24A/UB04 Box 45)
7. Place of service (CMS Box 24B)

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>01</td>
</tr>
<tr>
<td>School</td>
<td>03</td>
</tr>
<tr>
<td>Homeless shelter</td>
<td>04</td>
</tr>
<tr>
<td>Prison - Correctional facility</td>
<td>09</td>
</tr>
<tr>
<td>Office</td>
<td>11</td>
</tr>
<tr>
<td>Home</td>
<td>12</td>
</tr>
<tr>
<td>Assisted living facility</td>
<td>13</td>
</tr>
<tr>
<td>Group home</td>
<td>14</td>
</tr>
<tr>
<td>Mobile unit</td>
<td>15</td>
</tr>
<tr>
<td>Walk-in retail clinic</td>
<td>17</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>20</td>
</tr>
</tbody>
</table>
Physician Services/Plan Providers

21 Inpatient hospital
22 Outpatient hospital
23 Emergency room – hospital
24 Ambulatory surgical center
25 Birthing center
31 Skilled nursing facility
32 Nursing facility
33 Custodial care facility
34 Hospice
41 Ambulance – Land
42 Ambulance – Air/Water
49 Independent clinic
51 Inpatient psychiatric facility
52 Psychiatric facility – partial hospitalization
53 Community mental health center
54 Intermediate care facility/mentally handicapped
55 Psychiatric residential treatment center
57 Non-residential substance abuse treatment facility
60 Mass immunization center
61 Comprehensive inpatient rehabilitation facility
62 Comprehensive outpatient rehabilitation facility
65 End-stage renal disease treatment facility
71 Public health clinic
72 Rural health clinic
81 Independent laboratory

8. Assignment of Benefit (CMS Box 13)

9. CPT or HCPCS code (CMS Box 24D) or RV code (UB04 Box 42)

10. Charges (CMS Box 24 F/UB04 47)

11. Days or units (CMS Box 24G/UB04 Box 46)

12. Other insurance, if applicable (CMS Box 11a-d D/ UB04 Box 50)

13. Tax I.D. (CMS Box 25/ UB04 Box 5)

14. Referring physician, if applicable(CMS Box 17)

- It is necessary to include all of this information on a claim and to ensure the alignment of the information is within the boxes. Failure to include this information may result in claims being returned, denied or incorrectly paid.
Physician Services/Plan Providers

- If you have questions about member eligibility, member numbers, provider numbers, a claim’s status or claim issues, please call our Provider Service Department at (608) 282-8900 or (800) 545-5015.

Claims Address

Physicians Plus Insurance - Claims
P.O. Box 2078
Madison, Wi 53701-2078
Physician Services/Plan Providers

Physicians Plus
Accepts Physician and Hospital Claims Electronically

Physicians Plus Insurance Corporation works with the following major EDI clearinghouses:

Emdeon
Optum (Netwerkes)
Outsource

Physicians Plus Payor ID = 39156

Please contact the clearinghouse or your Provider Network Liaison directly if you need more information on how to start submitting claims electronically to Physicians Plus. Other EDI vendors, clearinghouses, billing services or software vendors may already be connected through Optum (Netwerkes), Emdeon or Outsource, Inc to Physicians Plus.

If you have any general questions regarding electronic claim submission, please contact your Provider Network Liaison.

NOTE: Physicians Plus does not accept dental, pharmaceutical, subrogation or workers compensation claims electronically.

Provider Numbers

Physicians Plus processes claims using the National Provider Identifier (NPI). Beginning May 23, 2007, this number is required on all CMS 1500 and UB04 claim forms. Each provider should have applied for and received an NPI. Please remember the provider numbers determine claim payment, so it is essential to report the NPI on the CMS 1500 (Box 24J) or UB04 (Box 56) claim forms.

Hospital Audits

Physicians Plus may perform audits on select inpatient claims retrospectively and compare to medical record information to ensure the accuracy of billing. Physicians Plus may contract with a third party vendor to perform audits on our behalf.
Physician Services/Plan Providers

Coding Requirements
Physicians Plus follows the coding guidelines of the Center for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), CPT, ICD-9 and ICD-10. Clarification and the appropriate use of specific codes is communicated to providers through memos and our provider newsletter. Please pay attention to the use of units and modifiers and use them appropriately.

Annual Coding Updates
Physicians Plus acknowledges that new and updated HCPCS, and CPT codes are available prior to January 1st each year. However, Physicians Plus will not accept the new and updated codes until January 1 each calendar year. When new ICD codes come out, they are valid October 1 of that year.

Coding Highlights
Physicians Plus uses the Non-Facility Total RVU to determine what code is considered primary and what code(s) should have the modifier 51 reduction. For most major surgeries, the RVU is the same for both the facility and non-facility, but when there is a difference, Physicians Plus uses the Non-Facility Total RVU. When the Non-Facility Total RVU is not listed, the Facility Total RVU is used.

Additional coding guidelines are available at www.pplusic.com, “Providers”, “Updates and Regulations” “Coding Guidelines”, or by clicking http://www.pplusic.com/providers/updates/coding

Coding Questions
If you have questions regarding coding or billing procedures, please call our Provider Services Department at (608) 282-8900 or (800) 545-5015.
PAYMENT OF CLAIMS

Provider checks are processed and mailed once a week. An explanation and example of the provider remittance advice form is included in this section.

Questions about the Payment or Denial of a Claim

A request to review a claim denial or payment must be submitted to Physicians Plus within six (6) months of the claim determination, unless specifically stated otherwise in the provider agreement.

1) Physicians Plus has created PlusLink, a secure, online resource designed to help you with day-to-day interaction with Physicians Plus. By logging on to PlusLink through our website, www.pplusic.com, you can view claims and complete a Claim Adjustment Review Request (CARR) form. Using PlusLink is the quickest way to have a claim reprocessed.

2) If you have questions regarding payment or denial of a claim, please contact our Provider Services Department at (608) 282-8900 or (800) 545-5015. When contacting Physicians Plus by telephone for assistance with a claim, please have the member name, member number, provider name and date of service available. If the claim in question requires adjusting, the representative assisting you will complete an adjustment request and forward it to our Claims Department.

3) To request a review, complete a CARR form on paper and mail it to Physicians Plus. It can be found at www.pplusic.com “Providers”, “Provider Manual & Forms”, or by clicking http://www.pplusic.com/providers/forms

4) CARR forms should be mailed to the appropriate address as indicated on the CARR form. If you choose to use the CARR form, please attach a copy of the provider remittance advice or original claim. If there is a primary payer other than Physicians Plus, a copy of the primary payer’s remittance advice must be attached.
Physician Services/Plan Providers

5) If you receive an incorrect claim payment, please do not refund the money without using one of the resources provided to you by Physicians Plus.

PLUSLIN

PlusLink is a secure, online management tool that gives providers access to health plan information and tools 24 hours a day, 7 days a week. By logging on and creating a new PlusLink account you can:

• Check the status of claims and authorizations
• View member benefit and eligibility information
• Submit Claim Adjustment Review Request (CARR) forms
• Submit Prior Authorization request
• Send secure messages to Physicians Plus Provider Services

Setting Up a Provider PlusLink Account

To create a PlusLink account, please click www.pplusic.com
Remittance Advice Key

1. Physicians Plus claims address.
2. Physicians Plus provider service phone number.
3. Name and address of provider to whom the check is issued.
4. Check Date: Date check was run.
5. Check #: Check number that corresponds to the remittance.
6. Patient Name: Name of patient billed on claim.
7. Member #: Physicians Plus member number of the patient.
8. Claim #: Number assigned to claim for processing.
9. Patient Account: Clinic account number as submitted on claim form.
10. Provider: Name of provider.
11. Provider ID: Number assigned to provider who provided services.

Items 12 – 25 correspond to the boxed column headings.

12. Service Date: Date(s) of service submitted on claim.
15. Allowed Amount: Per provider contractual agreement.
16. Deductible Amount: Amount applied to member’s deductible. *MEMBER RESPONSIBILITY*
17. Co-pay Amount: Amount of copayment. *MEMBER RESPONSIBILITY*
19. Discount Managed Care Adjust: Provider contracted discount. *PROVIDER RESPONSIBILITY*
20. Denied Amount: Charges ineligible for payment. *PROVIDER OR MEMBER RESPONSIBILITY*
22. OC: Number of units billed for the service code.
23. ANSI Code: American National Standards Institute (ANSI) code number assigned to claim adjustment reason codes.
Physician Services/Plan Providers

25. Patient Responsibility: Total of all columns for which member is responsible.
26. Description of ANSI code.
27. Totals: Totals all columns of the claim.
28. Statement Totals: Totals each column included on the remittance.
COORDINATION OF BENEFITS (COB)

Often members have more than one group health insurance policy. Coordination of Benefits determines which policy is considered primary coverage for that person or family. It also determines how payments will be made by each policy, including Medicare.

Determination of Payments

The group health insurance policy that covers the patient as a subscriber is the primary payer. For example, let’s say that John and Mary are married or domestic partners. If John has a group health policy through his employer, that policy is primary for any medical bills that John incurs. After that group health plan makes its payment, any balance that is the patient’s responsibility may be sent to Mary’s group health plan which is the secondary payer.

Determining which Policy to Bill for Dependents

When there are children involved, the “birthday rule” applies as follows: The insurance policy of the parent or legal guardian whose birthday falls earlier in the year has the primary payment responsibility for any dependent children. If John’s birthday is in March and Mary’s is in June, John’s policy would have primary responsibility for the children. Remember, the year of birth does not matter, just the month. In a divorce, the divorce decree or custody ruling may specify which policy is primary.

How to Report Services when Physicians Plus is Secondary

The primary carrier should be billed first and a copy of the remittance advice from the primary carrier must accompany your claims when they are sent to the Physicians Plus claims address.

It is possible that the patient has not given you information about other insurance coverage. If that is the case, the claim will be denied with a COB reason code that indicates the reason for the denial. When the primary carrier has processed the claim you may submit any balance due, which is the patient’s responsibility, to Physicians Plus.

You may not submit contractual discount amounts. Please remember to include the remittance advice from the primary payer.
Physician Services/Plan Providers

COB Refunds

Should you receive a payment in error, please notify Physicians Plus. Any overpayment will be recovered online or we will send you a refund request.

Please complete a CARR form when sending a COB refund to Physicians Plus. It can be found at www.pplusic.com, “Providers”, “Provider Manual & Forms”, or by clicking http://www.pplusic.com/providers/forms

Mail to:

Physicians Plus Insurance Corporation Attn: Adjustment Dept.
P.O. Box 2078
Madison, WI 53701-2078
SUBROGATION (Does not apply to Worker’s Compensation Claims)

Often you will see patients who have been injured (i.e. motor vehicle accidents, dog bites, and falls). Because there may be a potential for recovery from another party it is important for your office to indicate the type of injury in box 10 of your CMS1500 or box 32 on the UB04 claim form.

Based on the information presented on the claim, Physicians Plus will investigate the potential for recovery from another carrier. This recovery may come from either medical payment coverage or another third party.

The investigation process begins at the member level. Optum is the subrogation vendor for Physicians Plus and will contact the member requesting specific information relating to their injury. If medical payment coverage is available the claim may be denied as services paid by another insurance carrier. In these instances, please contact Optum for further information. Optum’s phone number is 800-529-0577.

For all other accident cases, Physicians Plus will process the claim according to the plan benefits. Physicians Plus will then pursue recovery of any benefit provided if another party is responsible. We understand subrogation can be a complicated process. If you have any questions, please contact our subrogation administrator at Optum at 800-529-0577.
WORKER’S COMPENSATION

Physicians Plus does not cover injuries or illnesses that are covered by Workers’ Compensation. DO NOT include these charges in any claims submitted to Physicians Plus. The employer’s Worker’s Compensation carrier should be billed for these charges. If, however, you wish to submit claims so that they are on file with Physicians Plus, please send them to:

Physicians Plus Insurance Corporation
Subrogation Department
2650 Novation Parkway
Suite 400
Madison, WI 53713

Indicate that they are work-related and we will have them entered into our claims system and denied.

If the Worker’s Compensation carrier denies the submitted claims, the member must go through the appeal process with their Worker’s Compensation carrier. If the appeal is denied, the member must submit the denial and itemized bill to Physicians Plus at the above address within 60 days from the last appeal for processing.
Surgical Assistant Reimbursement Schedule

Physicians Plus will reimburse for surgical assistant procedures using the Centers for Medicare and Medicaid Services (CMS) guidelines and payment policies. A Surgical Assistant Reimbursement Schedule will no longer be available.

Reporting of Surgical Assistant Modifiers
Physicians Plus will allow the following modifiers for the reporting of surgical assistants.

Modifier 80 - describes an assistant at surgery providing full assist to the primary surgeon. This modifier is not intended for use by non-physician assistants (e.g., RN, PA).

Modifier 81 - describes a minimal assistant at surgery providing minimal assistance to the primary surgeon. This modifier is not intended for use by non-physician assistants (e.g., RN, PA).

Modifier 82 - describes an assistant surgeon provided by an MD when a qualified resident surgeon is not available.

Modifier AS - describes a non-physician assistant at surgery. This would include services provided by physician assistants, nurse practitioners or clinical nurse specialists.

Reimbursement Guidelines
Physicians Plus will reduce reimbursement as follows due to the presence of the assistant surgeon modifier. Do not reduce your fees for assistant surgeons. Physicians Plus will reduce your fee accordingly.

Modifier -80 and -82 will be reimbursed at 20% of the allowance for the primary surgery. Modifier -81 and -AS will be reimbursed at 10% of the allowance for the primary surgery.