Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
93970	DUP-SCAN XTR VEINS COMPLETE BILATERAL STUDY	NONE
93971	DUP-SCAN XTR VEINS UNILATERAL/LIMITED STUDY	NONE
94010	SPMTRY W/VC EXPIRATORY FLO W/WO MXML VOL VNTJ	NONE
95004	PERCUTANEOUS TESTS W/ALLERGENIC EXTRACTS	NONE
95117	PROF SVCS ALLG IMMNTX X W/PRV ALLGIC XTRCS NJXS	NONE
95165	PREPJ& ALLERGEN IMMUNOTHERAPY 1/MLT ANTIGEN	NONE
95810	POLYSOM 6/>YRS SLEEP 4/> ADDL PARAM ATTND	NONE
95811	POLYSOM 6/>YRS SLEEP W/CPAP 4/> ADDL PARAM ATTND	NONE
95886	NEEDLE EMG EA EXTREMTY W/PARASPINL AREA COMPLETE	NONE
95941	IONM REMOTE/NEARBY/>1 PATIENT IN OR PER HOUR	NONE
95951	LOCALIZE CEREBRAL SEIZURE CABLE/RADIO EEG/VIDEO	NONE
96110	DEVELOPMENTAL SCREEN W/SCORING & DOC STD INSTRM	NONE
96372	THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM	NONE
96413	CHEMOTX ADMN IV NFS TQ UP 1 HR 1/1ST SBST/DRUG	NONE
97012	APPL MODALITY 1/> AREAS TRACTION MECHANICAL	NONE
97014	APPL MODALITY 1/> AREAS ELEC STIMJ UNATTENDED	NONE
97035	APPL MODALITY 1/> AREAS ULTRASOUND EA 15 MIN	NONE
97110	THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES	NONE
97112	THER PX 1/> AREAS EACH 15 MIN NEUROMUSC REEDUCA	NONE
97140	MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES	NONE
97161	PHYSICAL THERAPY EVALUATION LOW COMPLEX 20 MINS	NONE
97162	PHYSICAL THERAPY EVALUATION MOD COMPLEX 30 MINS	NONE
97530	THERAPEUT ACTVITY DIRECT PT CONTACT EACH 15 MIN	NONE
97811	ACUPUNCTURE 1/> NDLS W/O ELEC STIMJ EA 15 MIN	NONE
98940	CHIROPRACTIC MANIPULATIVE TX SPINAL 1-2 REGIONS	NONE
98941	CHIROPRACTIC MANIPULATIVE TX SPINAL 3-4 REGIONS	NONE
98943	CHIROPRACTIC MANIPLTV TX EXTRASPINAL 1/> REGION	NONE
99202	OFFICE OUTPATIENT NEW 20 MINUTES	NONE
99203	OFFICE OUTPATIENT NEW 30 MINUTES	NONE
99204	OFFICE OUTPATIENT NEW 45 MINUTES	NONE
99205	OFFICE OUTPATIENT NEW 60 MINUTES	NONE
99211	OFFICE OUTPATIENT VISIT 5 MINUTES	NONE
99212	OFFICE OUTPATIENT VISIT 10 MINUTES	NONE
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	NONE
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	NONE
99215	OFFICE OUTPATIENT VISIT 40 MINUTES	NONE
99220	INITIAL OBSERVATION CARE/DAY 70 MINUTES	NONE
99222	INITIAL HOSPITAL CARE/DAY 50 MINUTES	NONE
99223	INITIAL HOSPITAL CARE/DAY 70 MINUTES	NONE
99231	SBSQ HOSPITAL CARE/DAY 15 MINUTES	NONE
99232	SBSQ HOSPITAL CARE/DAY 25 MINUTES	NONE

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
99233	SBSQ HOSPITAL CARE/DAY 35 MINUTES	NONE
99238	HOSPITAL DISCHARGE DAY MANAGEMENT 30 MIN/<	NONE
99239	HOSPITAL DISCHARGE DAY MANAGEMENT > 30 MIN	NONE
99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN	NONE
99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	NONE
99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN	NONE
99245	OFFICE CONSULTATION NEW/ESTAB PATIENT 80 MIN	NONE
99254	INITIAL INPATIENT CONSULT NEW/ESTAB PT 80 MIN	NONE
99255	INITIAL INPATIENT CONSULT NEW/ESTAB PT 110 MIN	NONE
99283	EMERGENCY DEPARTMENT VISIT MODERATE SEVERITY	NONE
99284	EMERGENCY DEPARTMENT VISIT HIGH/URGENT SEVERITY	NONE
99285	EMERGENCY DEPT VISIT HIGH SEVERITY&THREAT FUNCJ	NONE
99291	CRITICAL CARE ILL/INJURED PATIENT INIT 30-74 MIN	NONE
99385	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	NONE
99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	NONE
99391	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y	NONE
99392	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS	NONE
99393	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS	NONE
99394	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS	NONE
99395	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS	NONE
99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	NONE
99460	1ST HOSP/BIRTHING CENTER CARE PER DAY NML NB	NONE
99468	1ST INPATIENT CRITICAL CARE PR DAY AGE 28 DAYS/<	NONE
99469	SUBQ I/P CRITICAL CARE PR DAY AGE 28 DAYS/<	NONE
99472	SUBSQ PED CRITICAL CARE 29 DAYS THRU 24 MO	NONE
99479	SUBSEQUENT INTENSIVE CARE INFANT 1500-2500 GRAMS	NONE
99480	SUBSEQUENT INTENSIVE CARE INFANT 2501-5000 GRAMS	NONE
G0121	Colonoscopy on individual not meeting criteria for high risk	NONE
G0202	Screening mammography, bilateral, including cad	NONE
G0204	Diagnostic mammography, including cad, bilateral	NONE
G0206	Diagnostic mammography, including cad; unilateral	NONE
G0283	Electrical stimulation (unattended)	NONE
G0481	Drug test(s), definitive,	NONE
G6015	Intensity modulated treatment delivery	NONE
J0129	Injection, abatacept, 10 mg	NONE
J0178	Injection, aflibercept, 1 mg	NONE
J0180	Injection, agalsidase beta, 1 mg	NONE
J0256	Injection, alpha 1 proteinase inhibitor	NONE
J0490	Injection, belimumab, 10 mg	NONE
J0585	Injection, onabotulinumtoxina, 1 unit	NONE
J0696	Injection, ceftriaxone sodium, per 250 mg	NONE

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
J0878	Injection, daptomycin, 1 mg	NONE
J0897	Injection, denosumab, 1 mg	NONE
J1300	Injection, eculizumab, 10 mg	NONE
J1459	Injection, immune globulin, iv, non-lyophilized,500 mg	NONE
J1559	Injection, immune globulin (hizentra), 100 mg	NONE
J1561	Injection, immune globulin, non-lyophilized, 500 mg	NONE
J1569	Injection, immune globulin, non-lyophilized, 500 mg	NONE
J1745	Injection, infliximab, excludes biosimilar, 10 mg	NONE
J2323	Injection, natalizumab, 1 mg	NONE
J2353	Injection, octreotide, 1 mg	NONE
J2357	Injection, omalizumab, 5 mg	NONE
J2469	Injection, palonosetron hcl, 25 mcg	NONE
J2505	Injection, pegfilgrastim, 6 mg	NONE
J3262	Injection, tocilizumab, 1 mg	NONE
J3490	Unclassified drugs	NONE
J7192	Factor viii per i.u., not otherwise specified	NONE
J7298	Levonorgestrel-releasing intrauterine contraceptive system	NONE
J7325	Hyaluronan or derivative, for intra-articular injection, 1 mg	NONE
J9035	Injection, bevacizumab, 10 mg	NONE
J9041	Injection, bortezomib, 0.1 mg	NONE
J9171	Injection, docetaxel, 1 mg	NONE
J9263	Injection, oxaliplatin, 0.5 mg	NONE
J9264	Injection, paclitaxel protein-bound particles, 1 mg	NONE
J9305	Injection, pemetrexed, 10 mg	NONE
J9306	Injection, pertuzumab, 1 mg	NONE
J9310	Injection, rituximab, 100 mg	NONE
J9355	Injection, trastuzumab, 10 mg	NONE
S2068	Breast reconstruction w deep inferior epigastric perforator	NONE
S9083	Global fee urgent care centers	NONE
Codes Not Specified Above		
0XXXX	Unspecified Codes in 00000-09999	NONE
1XXXX	Unspecified Codes in 10000-19999	50, 51, 52, AS, AN, ZZ
2XXXX	Unspecified Codes in 20000-29999	50, 51, 52, AS, AN, ZZ
3XXXX	Unspecified Codes in 30000-39999	50, 51, 52, AS, AN, ZZ
4XXXX	Unspecified Codes in 40000-49999	50, 51, 52, AS, AN, ZZ
5XXXX	Unspecified Codes in 50000-59999	50, 51, 52, AS, AN, ZZ
6XXXX	Unspecified Codes in 60000-69999	50, 51, 52, AS, AN, ZZ
7XXXX	Unspecified Codes in 70000-79999	26, 50, 51, 52, ZZ
8XXXX	Unspecified Codes in 80000-89999	26, 50, 51, 52, ZZ
9XXXX	Unspecified Codes in 90000-99999	NONE
AXXXX	Unspecified HCPCS Codes AXXXX	NONE

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

Code	Description	Modifiers to Report
BXXXX	Unspecified HCPCS Codes BXXXX	NONE
CXXXX	Unspecified HCPCS Codes CXXXX	NONE
EXXXX	Unspecified HCPCS Codes EXXXX	NONE
GXXXX	Unspecified HCPCS Codes GXXXX	NONE
JXXXX	Unspecified HCPCS Codes JXXXX	NONE
KXXXX	Unspecified HCPCS Codes KXXXX	NONE
LXXXX	Unspecified HCPCS Codes LXXXX	NONE
QXXXX	Unspecified HCPCS Codes QXXXX	NONE
SXXXX	Unspecified HCPCS Codes SXXXX	NONE
ZZZZZ	Claim lines with invalid CPT Code	NONE

If codes exist outside the CPT/HCPCS ranges shown above, create another grouping using the first character of the CPT/HCPCS code followed by 4 X's. As an example, if a code begins with T, create a grouping TXXXX for all claim lines with these codes.

Appendix E –Modifiers to be Submitted by CPT Code Range

CPT Code Range	Modifiers to be Submitted	Note
10000 – 69999	• Bilateral Procedures (50) • Multiple Procedures (51) • Reduced Services (52) • Assistant Surgeon (AS) • Anesthesiologist (AN) • Primary Surgeon, Uncoded, Other or Unknown (ZZ)	**These modifiers apply to the submission of Professional claims only.** Based on standard coding of CPT Modifiers, Bilateral Procedure are coded with Modifier 50, Multiple Procedures are coded with Modifier 51, Reduced Services are coded with Modifier 52, Anesthesia by a surgeon is typically coded with Modifier 47 and Assistant Surgeon is typically coded with Modifier 80, 81 or 82. Carriers must affirm that they have been diligent in identifying any homegrown modifiers used in their claim processing. All homegrown codes must be mapped to the 3 codes shown (AS, AN, ZZ)
Radiology 70000 – 79999 Pathology 80000 – 89999	• Bilateral Procedure (50) • Multiple Procedures (51) • Reduced Services (52) • Global Fee (GF) • Technical Component (TC) • Professional Component (PC) • Uncoded, Other or Unknown (ZZ)	**These modifier rules apply to the submission of both Outpatient Facility and Professional claims.** Based on standard coding of CPT Modifiers, the Technical Component is typically coded as Modifier "TC" and the Professional Component is typically coded as Modifier "26". Global Fee (GF) modifiers must be identified by the carrier Modifiers 26 or PC should not appear in Outpatient Facility data as these indicate the Professional services. Likewise, modifiers TC and GF should not appear in Professional data as these modifiers indicate Outpatient facility charges. Carriers must affirm that they have been diligent in identifying any homegrown modifiers used in their claim processing. All homegrown codes must be mapped to the 4 codes shown (GF, TC, PC, ZZ)
All other codes	• None submitted	Modifiers for CPT codes not falling into the specific ranges noted in the categories above should not be submitted

Appendix F – Control Total/Reconciliation

The following schedule should be provided for each product for which a "Product Indicator" is provided.

ACTUAL CLAIMS RECONCILIATION	**Product 1**	**Product 2**	**Product 3**	**Product 4**
Fee for Service Claims Included				
Total Submitted Charges				
- Total Ineligible Charges				
= Total Eligible Billed Charges				
- Negotiated Savings				
- Reasonable & Customary Cutback Amount				
= Total Allowed Amount				
- Member Cost-Sharing Amounts				
= Plan Paid Amount				
Other Provider Payments				
Other Provider Payments $ - Direct				
Other Provider Payments $ - Indirect				
Total Other Provider Payments				
Other Key Summaries				
Total Eligible Billed Charges where Pay as Billed Indicator = "Y"				
Total Eligible Billed Charges where Patient 3-Digit Zip Code = "ZZZ"				

ADJUSTED CLAIMS RECONCILIATION	**Product 1**	**Product 2**	**Product 3**	**Product 4**
Fee for Service Claims Included				
Total Submitted Charges				
- Total Ineligible Charges				
= Total Eligible Billed Charges				
- Negotiated Savings				
- Reasonable & Customary Cutback Amount				
= Total Allowed Amount				
- Member Cost-Sharing Amounts				
= Plan Paid Amount				
Other Provider Payments				
Other Provider Payments $ - Direct				
Other Provider Payments $ - Indirect				
Total Other Provider Payments				
Other Key Summaries				
Total Eligible Billed Charges where Pay as Billed Indicator = "Y"				
Total Eligible Billed Charges where Patient 3-Digit Zip Code = "ZZZ"				

PROJECTED CLAIMS RECONCILIATION	**Product 1**	**Product 2**	**Product 3**	**Product 4**
Fee for Service Claims Included				
Total Submitted Charges				
- Total Ineligible Charges				
= Total Eligible Billed Charges				
- Negotiated Savings				
- Reasonable & Customary Cutback Amount				
= Total Allowed Amount				
Other Provider Payments				
Other Provider Payments $ - Direct				
Other Provider Payments $ - Indirect				
Total Other Provider Payments				
Other Key Summaries				
Total Eligible Billed Charges where Pay as Billed Indicator = "Y"				
Total Eligible Billed Charges where Patient 3-Digit Zip Code = "ZZZ"				

Appendix G - Product Key

Product Name and Description	Product Indicator
Open Choice	PPO01Choice
Open Choice Plus	PPO02ChoicePlus
Managed Options	POS01Options
Gatekeeper Plus	POS02GKPlus

* Positions 1 through 3 should indicate product type (HMO, EPO, PPO, POS, TRA)
Positions 4 through 5 should be used to differentiate offerings within product type
Positions 6 through 15 should be used to indicate product name

Appendix H – Projection Documentation

PLEASE REFER TO PAGE 8 FOR INSTRUCTIONS ON COMPLETING THIS FORM

		1/20-12/20 Projected Discount Change* (+) means discount improvement (-) means discount deterioration				Annual Trend Applied to Eligible Billed Charges			% of Area Eligible Billed Charges Affected by Change				
Three Digit ZIP(s)	Product Indicator	IP	OP	Prof	Change to Total Discount	IP	OP	Prof	IP	OP	Prof	Total	Discount Improvement Plan Details
AXY	PPO01	2.00%	2.00%	0.00%	1.00%	6.00%	7.00%	0.00%	50.00%	41.00%	0.00%	22.75%	Renegotiated key facility contracts
AZY	PPO01	1.00%	1.00%	2.00%	1.50%	6.00%	7.00%	4.50%	15.00%	20.00%	100.00%	52.55%	Renegotiated key facility contracts Introduce New Physician Fee Schedule
VCX	POS01	0.00%	0.00%	4.00%	2.00%	0.00%	0.00%	4.50%	0.00%	0.00%	75.00%	33.75%	Introduce New Physician Fee Schedule

All projections and reasons for projections should be thoroughly explained in the Actuarial Certification (Appendix I)

* Changes should reflect absolute change in discount
(e.g., if discount expected to improve from 55% to 57%, Change in Discount is 2%; if discount expected to deteriorate from 63% to 60%, Change in Discount is -3%)
Change in discount should reflect expected changes in both Allowed Amount and Eligible Billed
Allowed amount should only be trended at 0% if carrier has a signed contract stating that Allowed amounts will remain unchanged

Common Discount Change Plan Detail Reason Types
Non-Par Hospital Contracting
Free Standing Surgical Centers Contracting
Change Stop Loss Provisions
Introduce New Physician Fee Schedule
Reduce Existing Physician Fee Schedule
Provider acquired by another provider
Par hospital re-contracting
Addition or loss of major hospital(s) in a location
Addition or loss of major group practice(s) in a location
Renegotiated major contract changes with existing network providers
Recognize negotiated escalators in multi-year contracts
This is not intended to be an exhaustive list. Please add other descriptive types as needed.

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
1	Data is reported by member 3-digit zip code. Data has not been combined for multiple three-digit zip codes			
2	For each product submitted, data includes 12 months of claims, incurred 1/1/2019-12/31/2019 and paid through 2/29/2020**.**			
3	All indicators in the data are mutually exclusive so that when amounts for charge and utilization fields are summed, the result is the actual total for that field.			
4	Data is submitted in the format outlined in Appendix A			
5	Data includes all claims (other than those exclusions outlined on page 1) regardless of provider contracting status, claim dollar amount or discount percentage			
6	Data excludes all surcharges and covered life assessments (e.g., NYCHRA in New York)			

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Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
7	Access fees are excluded from all claims. If access fees could not be removed explicitly, please submit data as "Adjusted" and provide your methodology in the box requesting explanation of Adjusted data below			
8	Minnesota provider tax payments have been included in both the 'Eligible Billed $' and 'Allowed $' fields.			
9	Data has been assembled as outlined on page 2 "Data Aggregation Methodology"			
10	A product indicator for each product submitted has been provided And Appendix G has been included with the submission			
11	Benefit/Contract Status Indicator has been submitted			
12	MDC and DRG have been provided for all inpatient claims			
13	DRG data has been submitted under coding system MS-DRGv36 and DRG Indicator Field has been coded properly in your data submission			

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Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
14	For a covered admission where the admission and discharge date are equal, the number of covered days is set to 1. There are no IP Admissions with 0 days			
15	Days and billed charges associated with non-covered days during a hospital admission have been excluded from the data submission			
16	Reversals offset submitted data for admissions, days, OP Services, procedures and dollar amount fields and are not treated as additional utilization/dollar amounts			
17	Financial data has been submitted as defined on pages 6 and 7 for Eligible Billed Charges, Negotiated Savings, Allowed Amount and Paid Amount			
18	Eligible Billed Charges are equal to the Billed Charge on the claim and have not been adjusted to reflect the Allowed Amount on the claim.			

Appendix I
Disclosure of Compliance with Data Standards

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Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
19	Ineligible billed charges (as defined on page 7) have been excluded and Eligible Billed Charges = Submitted Charges – Ineligible Charges for all claims			
20	All financial and utilization data labeled as "Actual" represents historical claims without adjustment			
21	All Other Provider Payments are included in Appendix A in the Other Provider Payments data.			
22	"Adjusted" data and "Projected" data have been explained in the space provided below and Appendix H has been submitted for "Projected" data			

Appendix I
Disclosure of Compliance with Data Standards

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Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
23	Contract changes included in "Projected" data were signed prior to the "cutoff" date of March 31, 2020			
24	The impact of newly signed contracts effective in a future time are only included in "Projected" data and are not included in "Adjusted" data			
25	Outpatient events for which facility and professional claims cannot be separated have been indicated with a modifier of "GF". If unable to label claims with modifier of "GF", please provide the total utilization and eligible billed charges for Outpatient events where facility and professional claims cannot be separated			
26	Ancillary claims as defined in Appendix C have been included in Outpatient Facility claims and excluded from Professional claims			
27	All homegrown modifier codes have been mapped to comply with modifier definitions shown in Appendix E			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
28	Appendix F has been completed for all products submitted. Total Submitted Charges represent all fee for service claims for a product after the criteria for inclusion/exclusion on page 1 is applied			
29	Has this submission kept separate the data for benefit plans with in-network only and in-network/out-of-network benefits?			
30	The Arrangement/Group Size Indicator field was populated using the definition found on page 5.			
31	All Other Provider Payments in Appendix A are based on paid amounts in the incurred Time Period.			
32	All Other Provider Payments are included in Appendix A in the Other Provider Payments data for both direct and indirect payments.			

Please provide a description of the process used to identify claims that have a Pay-as-Billed Indicator of "Y"

Please provide explanation and the methodology used to calculate any "Adjusted" claim or utilization data included in this data submission. Explanation should be provided by geographic area. Examples of reasons to provide "Adjusted" data can be found on page 8 of this document.

Please provide explanation and the methodology used to calculate any "Projected" claim or utilization data included in this data submission. Explanation should be provided by geographic area. Please address the level at which the projected discounts were calculated and applied (3 digit zip code or MSA). Appendix H should also be provided for each geographic area where "Projected" data is submitted

Please disclose any assumptions used to compile the data in the Other Provider Payments table in Appendix A. Please provide a definition of any custom values in the Other Provider Payment Type field. Please provide an explanation for changes in Other Provider Payment totals for Adjusted and Projected data.

Please disclose the amount of claims by Type of Service that were excluded for medical provider customers. In addition, please provide a list of zip codes where more than 5% of total claims in that zip code were excluded.

Please provide an explanation of any Medical Management/Medical Necessity language included in your provider contracts. In addition, please provide the percentage of claims, on an Eligible Billed basis, that are impacted by this language.

Please disclose the Eligible Billed and Allowed amounts of claims incurred outside of the United States. Only include claims for members who live in the United States and are included in the submission. The summary should be grouped by 3-Digit Patient Zip Code.

Please describe any alternative criteria used to identify and exclude claims for medical provider customers other than the criteria listed on page 2

Please disclose and explain any other deviations from this data specification that have not been addressed above

Please disclose any reliance you have made on other parties in completing this data submission as well as any other areas of concerns you may have as they relate to guidance offered under Actuarial Standard of Practice (ASOP) #23, Data Quality

By signing below, I certify that I have reviewed the data submitted. Based on my thorough review, I believe it presents a fair and accurate representation of the provider reimbursement arrangements of this organization, as reflected in book-of-business claims data. Except as disclosed above, we have followed the procedures outlined by in this document to fulfill the data request.

Carrier Name

Signature of Actuary | Printed Name

Title | Date

Appendix J – DRG Version Coding

The DRG Version Identifier is a 4 character field with format V### where:

V: Grouper Version Type Code
- A: CMS (Medicare grouper)
- B: All Payor (sometimes called "New York" grouper)
- C: All Payor Refined (APR grouper)
- D-J: reserved for future use
- K-Z: Other (to be specified in the actuarial certification)

###: Version number (e.g., "A270" is the Medicare grouper effective 10/1/2009)
The first two digits relate to the DRG version number (for example, MS-DRG v36 is coded as 36).
The last digit is a placeholder as sometimes there are corrections released during a year. If a correction is released, the last digit would change from '0' to the correction number of the DRG release used (i.e., A271)

Appendix K – Product Audit File

The following table should be completed and included in the UDS submission.

Category	Eligible Billed Charges	Notes
All Eligible Billed Charges		Includes all medical claims for commercial products
- Claims from Individual Policies		
- Excluded Funding Arrangement Claims		List funding arrangements excluded
- Excluded Products		List and describe products excluded
- Claims from Members > 65 years old		
- Claims from Medicare Supplement Plans		
- Claims with COB and as secondary payer		
- Rx, Dental, Vision claims not covered under medical benefit		
- Claims from Custom Networks		
- Claims from Prison / Railroad groups		
- Claims from Medical Provider Customers		
- Other Exclusion		Provide a description
- Other Exclusion		Provide a description
- Other Exclusion		Provide a description
- Other Exclusion		Provide a description
- Other Exclusion		Provide a description
Total Eligible Billed Charges from Appendix F (Actuals)		

Appendix L – Servicing Provider State

The table below should be created for the following markets.

1. Atlanta, GA (zips 300-303, 311)
2. Fairfield, CT (066, 068, 069)
3. State of Maryland (206-219)
4. Newark, NJ (070-073)
5. Riverside-San Bernardino, CA (922-925)
6. San Angelo-Midland, TX (768, 769, 797)

The zip codes listed above are in reference to the patient zip code, not the provider zip code. Claims should be included for all patients who reside in one of the requested zip codes and are included in the UDS submission.

	Field	Notes/Sample Values	Aggregation Function
REQUIRED FIELDS			
1	Organization Name	Name of organization providing data	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, **calendar year 2019** data, this field would be populated as **010119-123119**. If period is not equal to 12 months, it should be disclosed on the actuarial certification	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	Group by
4	3 Digit Service Provider ZIP Code	Use zip code where the service was provided, not the billing zip code. If the provider's zip code is not available, zip code should be set to "ZZZ"	Group by
5	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum

Change Log

1) Changes from Calendar Year 2017 Specification to Mid-Year 2018 Specification

a) Deleted list of changes from Calendar Year 2015 Specification to Mid-Year 2016 Specification
b) Version and Date in Header Changed to Version MY2018.1 and August 31, 2018 (all pages)
c) Updated incurred date from 1/1/2017-12/31/2017 and paid through 2/28/2018 to 7/1/2017-6/30/2018 and paid through 8/31/2018
   i) Page 1, 44
d) Updated Incurred date from 010117-123117 to 070117-063018
   i) Page 4, 17, 20, 23, 25, 27
e) Updated Incurred date from 1/1/2017-12/31/2017 to 7/1/2017-6/30/2018
   i) Pages 9
f) Projected Data Submission Dates
   i) Page 9 – change from "Only contracts executed by March 31, 2018..." to "Only contracts executed by September 30, 2018…"
   ii) Page 48 – change from "date of March 31, 2018" to "date of September 30, 2018".
g) Updated Projected period from 1/1/2018-12/31/2018 to 1/1/2019-12/31/2019
   i) Page 9
h) Changed "calendar year 2017" to "mid-year 2018"
   i) Page 4, 17, 20, 23, 25, 27
i) Updated dates in Appendix H
   i) Page 43
j) Updated list of codes in Appendix D
   i) Page 31
k) Added Appendix K
   i) Page 54

2) Changes from Mid-Year 2018 Specification v1 to Mid-Year 2018 Specification v2

a) Version and Date in Header Changed to Version MY2018.2 and November 8, 2018 (all pages)
b) Added Appendix L
   i) Page 55

3) Changes from Mid-Year 2018 Specification v2 to Calendar Year 2018 Specification

a) Deleted list of changes from Mid-Year 2016 Specification to Calendar Year 2016 Specification
b) Version and Date in header changed to Version CY2018.1 and March 15, 2019 (all pages)
c) Updated incurred date from 7/1/2017-6/30/2018 and paid through 8/31/2018 to 1/1/2018-12/31/2018 and paid through 2/28/2019
   i) Page 1, 44
d) Updated Incurred date from 070117-063018 to 010118-123118
   i) Page 4, 17, 20, 23, 25, 27, 56
e) Updated Incurred date from 7/1/2017-6/30/2018 to 1/1/2018-12/31/2018
   i) Pages 9
f) Projected Data Submission Dates
   i) Page 9 – change from "Only contracts executed by September 30, 2018…" to "Only contracts executed by March 31, 2019..."
   ii) Page 48 – change from "date of September 30, 2018" to "date of March 31, 2019".

g) Changed "mid-year 2018" to "calendar year 2018"
   i) Page 4, 17, 20, 23, 25, 27, 56
h) Reviewed Billed Charge trends in Appendix B. Determined no update was required.
   i) Page 28
i) Updated DRG version to v35
   i) Page 12, 17, 45, 54
j) Updated exhibits for projected discounts
   i) Page 11
k) Add language to specify that the Catastrophic Indicator should be based on Actual Allowed
   i) Page 12
l) Added box in Appendix I related to Medical Management/Medical Necessity language included in provider contracts.
   i) Page 51
m) Added box in Appendix I requesting summary of International claims
   i) Page 52

4) Changes from Calendar Year 2018 Specification to Mid-Year 2019 Specification

a) Deleted list of changes from Calendar Year 2016 Specification to Mid-Year 2017 Specification
b) Version and Date in Header Changed to Version MY2019.1 and August 30, 2019 (all pages)
c) Updated incurred date from 1/1/2018-12/31/2018 and paid through 2/28/2019 to 7/1/2018-6/30/2019 and paid through 8/31/2019
   i) Page 1, 44
d) Updated Incurred date from 010118-123118 to 070118-063019
   i) Page 4, 17, 20, 23, 25, 27, 56
e) Updated Incurred date from 1/1/2018-12/31/2018 to 7/1/2018-6/30/2019
   i) Pages 9
f) Projected Data Submission Dates
   i) Page 9 – change from "Only contracts executed by March 31, 2019..." to "Only contracts executed by September 30, 2019…"
   ii) Page 48 – change from "date of March 31, 2019" to "date of September 30, 2019".
g) Updated Projected period from 1/1/2019-12/31/2019 to 1/1/2020-12/31/2020
   i) Page 9
h) Changed "calendar year 2018" to "mid-year 2019"
   i) Page 4, 17, 20, 23, 25, 27, 56
i) Updated dates in Appendix H
   i) Page 43
j) Updated list of modifiers in Appendix D for Radiology and Pathology codes
   i) Pages 33-35, 38

5) Changes from Mid-Year 2019 Specification v1 to Mid-Year 2019 Specification v2

a) Version and Date in Header Changed to Version MY2019.2 and January 7, 2020 (all pages)
b) Updated Projected period from 2019 to 2020
   i) Page 9
c) Updated dates referenced in discount projection examples
   i) Page 10

6) Changes from Mid-Year 2019 Specification to Calendar Year 2019 Specification

a) Deleted list of changes from Mid-Year 2017 Specification to Calendar Year 2017 Specification
b) Version and Date in Header Changed to Version CY2019.1 and March 9, 2020 (all pages)
c) Updated incurred date from 7/1/2018-6/30/2019 and paid through 8/31/2019 to 1/1/2019-12/31/2019 and paid through 2/29/2020
    i) Page 1, 44
d) Updated Incurred date from 070118-063019 to 010119-123119
    i) Page 4, 17, 20, 23, 25, 27, 56
e) Updated Incurred date from 7/1/2018-6/30/2019 to 1/1/2019-12/31/2019
    i) Pages 9
f) Projected Data Submission Dates
    i) Page 9 – change from "Only contracts executed by September 30, 2019…" to "Only contracts executed by March 31, 2020..."
    ii) Page 48 – change from "date of September 30, 2019" to "date of March 31, 2020".
g) Changed "mid-year 2019" to "calendar year 2019"
    i) Page 4, 17, 20, 23, 25, 27, 56
h) Reviewed Billed Charge trends in Appendix B. Determined no update was required.
    i) Page 28
i) Updated DRG version to v36
    i) Page 12, 17, 45, 54
j) Updated exhibits for projected discounts
    i) Page 11
k) Revised last exclusion to be based on SIC code
    i) Page 2
l) Added text box to Appendix I for data submitters to provide alternative methodology for identifying and excluding claims for medical providers
    i) Page 52