Medical Assistance Provider Bulletin

Attention: All Certified Providers of the Medical Assistance Program

Subject: General Policy Clarification

Date: June 1, 1988

Code: MAPB-088-040-X

The purpose of this bulletin is to (1) communicate new policies concerning Medical Assistance eligibility changes and limitations on Medicare coinsurance claims, (2) clarify or reiterate policies which were communicated in previous bulletins, and (3) correct errors which were printed in previous bulletins.

Overall, claims processing has improved steadily since February, although certain providers have experienced periodic problems. We expect to see continued reductions in claims processing time and appreciate the willingness of all providers and staff to work together to resolve any remaining problems. If you are continuing to have claims problems, please be sure to seek assistance from written correspondence or your field representative. See the numbers and addresses listed in the September 1, 1987, Medical Assistance Provider Bulletin MAPB-087-037-X. Please do not resubmit claims without verifying that they have been denied and are no longer pending in the system. Denied claims must be corrected before they are resubmitted. Resubmitting pending claims will add to the time needed to process both of the pending claims.

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Wisconsin Department of Health and Social Services, Division of Health, Bureau of Health Care Financing, Provider/Recipient Services, P.O. Box 309, Madison, Wisconsin 53701

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I. LIMITATION ON WISCONSIN MEDICAL ASSISTANCE PROGRAM PAYMENTS FOR MEDICARE PART B COINSURANCE

A provision of the 1987-1989 state budget Act 27, Chap. 20, for the Wisconsin Medical Assistance Program (WMAP) establishes a limitation on WMAP reimbursement for Medicare Part B coinsurance. This limitation is authorized by Section 49.46(2)(c), Wis. Stats. Effective for dates of service on and after July 1, 1988, WMAP payment for Medicare Part B coinsurance is limited to the WMAP maximum allowable fee less the Medicare payment for the service.

This requirement applies to all services (e.g., physician, therapy, durable medical equipment, transportation) where Medicare coinsurance is billed to the WMAP for recipients who are eligible for both Medicare Part B and Medical Assistance (dual entitlees). This change in reimbursement will occur automatically. All billing for coinsurance, as well as WMAP reimbursement for the Medicare Part B deductible, will be unchanged from current procedures.

For Medicare Part B coinsurance, WMAP will pay providers the lower of the following:

1. WMAP maximum allowable fee/rate less the Medicare payment, or

2. The Medicare coinsurance billed to the WMAP.

Any applicable copayment for WMAP services will be deducted from the WMAP payment to the provider.

The following examples illustrate how this limitation will work:

	Example I	Example II	Example III
A. Provider's charge for a service	$120	$120	$120
B. Medicare reasonable charge	100	100	100
C. WMAP maximum allowable fee for service	90	110	75
D. Medicare payment (80% of reasonable charge)	80	80	80
E. Maximum amount allowed for payment of coinsurance (i.e., WMAP fee less Medicare payment: C - D)	10	30	0
F. Medicare coinsurance billed to WMAP (20% of reasonable charge)	20	20	20
G. WMAP payment for coinsurance (lesser of E or F)	10	20	0

As a reminder, providers must accept assignment when billing both Medicare and the WMAP. In accordance with federal and state law and provider "Terms of Reimbursement," providers must accept WMAP payment for coinsurance as payment in full and may not charge recipients for any amount greater than WMAP's payment considered "unpaid" by the provider.

II. PRESUMPTIVE MEDICAL ASSISTANCE ELIGIBILITY FOR PREGNANT WOMEN

Effective July 1, 1988, the WMAP will implement the presumptive eligibility program discussed in Medical Assistance Provider Bulletin MAPB-087-038-X, dated December 21, 1987. Therefore, in the near future, providers may see pregnant women who present a beige WMAP identification card. The card will have validity dates handwritten across the top. These cards are for pregnant women who have presumptive Medical Assistance eligibility. The card is good only for ambulatory prenatal care and only when provided by a special presumptive eligibility Qualified Provider who has signed a Qualified Provider agreement with the Wisconsin Department of Health and Social Services (DHSS). Potential providers have been and will continue to be contacted by the Bureau of Health Care Financing with more detailed information about presumptive eligibility and becoming "Qualified Providers." If you are interested in more information about this program, please contact the Bureau of Health Care Financing, at (608) 266-2522.

No other WMAP certified providers will be reimbursed for any claims made under this beige presumptive eligibility card. (A sample presumptive eligibility identification card is shown in Attachment 1.) If a woman presents this card to a provider who does not have a signed qualified provider agreement with the DHSS, that provider should refer her back to the original Qualified Provider from whom she initially received her card and prenatal care.

III. MEDICAL ASSISTANCE ELIGIBILITY FOR ALIENS

A. New Medical Assistance (MA) Coverage for Aliens

Effective July 1, 1988, certain legal aliens may now be eligible for some MA coverage, if they meet all of the basic MA eligibility requirements. Under the Immigration Reform and Control Act (IRCA) of 1986 and state statutes, certain legal aliens will qualify for categorically needy or medically needy benefits. Providers who have contact with indigent aliens should refer these people to the county or tribal certifying agency -- Department of Social Services (DSS) or Human Services -- to make an MA application. Under IRCA, persons who are under age 18, over age 65, blind, or disabled who meet MA eligibility requirements may be covered. Pregnant women who have registered under the IRCA and meet MA eligibility requirements may also receive MA coverage.

B. MA Coverage of Emergency Services for Aliens

In addition, effective July 1, 1988, aliens are eligible for MA coverage of emergency services if the following conditions are met:

1. The alien has a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

   a. placing the patient's health in serious jeopardy,
   b. serious impairment to bodily functions, or
   c. serious dysfunction of any bodily organ or part.

2. To be eligible for MA coverage for emergency services, an alien meeting the above emergency medical criteria must also meet all other eligibility requirements applied to the rest of the MA population.

Aliens who qualify for coverage of emergency care only under the above conditions will not be issued WMAP cards. A provider who gives emergency care to an alien on or after July 1, 1988, should refer the claim to the local county or tribal Department of Social Services for a determination of MA eligibility coverage. The DSS will determine if WMAP coverage is available. If the alien can be certified for coverage, the DSS will return the claim to the provider along with the alien's WMAP recipient identification (ID) number. The provider may then submit the claim to EDS, using the alien's MA ID number. This number is only valid for emergency services. The claim submitted to EDS must clearly identify this as an emergency service in the appropriate box of the claim form, if applicable. Providers should attach supporting documentation (history and physical, discharge summary, operative report).

Emergency services are covered from the time the alien is first given treatment for an emergency medical condition until such time as the medical condition requiring emergency care is no longer an emergency. In the case of emergency labor and delivery services, coverage is from the time the mother is first treated for active labor until such time as delivery is complete and mother and child are stabilized.

IV. ELECTRONIC MEDIA CLAIMS

The WMAP asks providers currently submitting paper claims to consider using electronic billing. E.D.S. Federal Corporation (EDS) has the capability to accept electronic claims from providers. EDS continues to offer more electronic claim services to more providers. Many providers could benefit, since electronic claims are generally processed and paid faster than claims submitted on paper.

Please read Attachment 2 and take time to complete the Electronic Media Provider Survey Questionnaire.

V. CLARIFICATION OF BILLING INSTRUCTIONS CONCERNING DATES OF SERVICE

Effective with claims received at EDS June 1, 1988, and after, each detail line of the claim form must contain at least one date of service. Detail lines without a date of service indicated will be denied.

VI. LIMITATION ON SERVICES TO RESIDENTS OF AN INSTITUTION FOR MENTAL DISEASE (IMD) - CORRECTION TO MAPB-087-038-X

There was an error printed under Section V of the Medical Assistance Provider Bulletin MAPB-087-038-X, dated December 21, 1987. This should indicate that "Federal law does not allow Federal matching funds to be claimed for care in an Institution for Mental Diseases (IMD) for MA recipients aged 21 through 64."

VII. FAMILY PLANNING CLINICS, TYPE OF SERVICE CODES - CORRECTION

Family Planning Clinic providers were notified in January by telephone of the following correction:

> Attachment 4 of MAPB-087-006-P, dated September 1, 1987, indicated Family Planning Clinic providers should use type of service (TOS) code 9 for all services effective for claims received at EDS January 1, 1988, and after. Family Planning Clinic providers must use TOS code 5 or X for lab services and TOS 9 for all other services. Attachment 3 of this MAPB is a replacement page for Attachment 4 of the referenced bulletin.

VIII. CHIROPRACTIC PROVIDERS

Effective February 26, 1988, all HMOs contracting with the State of Wisconsin for Medical Assistance enrollment (WMAP-contracted HMO), except Group Health Cooperative of Eau Claire - HMOGHE,* have chosen to subcontract with the Department of Health and Social Services for chiropractic services. All covered chiropractic services provided after February 26, 1988, to a recipient enrolled in a WMAP-contracted HMO (except those enrolled in HMOGHE) may be billed on a fee-for-service basis directly to EDS. Recipients enrolled in WMAP-contracted HMOs can be identified by a yellow MA identification card.

Also effective February 26, 1988, all spinal supports provided by chiropractors to recipients enrolled in WMAP-contracted HMOs (excluding HMOGHE) may be billed fee-for-service directly to EDS.

Chiropractic providers should be aware of the following corrections to Attachments 1 and 6 in MAPB-087-005-G, dated September 1, 1987.

> Claim Form Attachment 1: Element 24D, "Diagnosis Code", refers to either the reference line number or the diagnosis code indicated in element 23A. Since there is only one diagnosis code in element 23A, the last two line items in element 24D should indicate a diagnosis code reference number of "1," not a "2."
>
> Prior Authorization Form Attachment 6: Element 14, "Procedure Code" indicates the old chiropractic procedure code for chiropractic adjustments. The correct code beginning January 1, 1988, is W9010. In element 17, "TOS," the indicator is 1. The correct TOS indicator for chiropractic adjustments is 9.

* Group Health Cooperative of Eau Claire (HMOGHE) provides chiropractic services through its HMO panel of chiropractic providers.

IX. HEARING AID PROVIDERS

Hearing aid providers are reminded that a large number of hearing aid battery codes were consolidated or deleted effective for dates of service on or after January 1, 1988. Hearing aid providers are experiencing a large number of denials because they have indicated incorrect procedure codes on their claim forms.

The updated procedure codes for batteries were indicated in MAPB-087-015-D/002-HA, dated September 1, 1987. If you wish to request any additions to the batteries listed in that bulletin, you may do so by writing to:

Bureau of Health Care Financing
P.O. Box 309
Madison, WI 53701.

X. PHYSICIAN AND HOSPITAL OUTPATIENT SERVICES AND HEARING AID BATTERIES - EXPLANATION OF COPAYMENT DEDUCTIONS

A. Physician and Hospital Outpatient Services

The new recipient copayments explained in Medical Assistance Provider Bulletin MAPB-087-038-X, dated December 21, 1987, are effective for dates of service on and after March 1, 1988. However, the current claims processing system deducts copayments according to the date of processing, rather than date of service. As a result, all physician and hospital outpatient claims processed and paid on the March 6, 1988, Remittance and Status Reports and on the Remittance and Status Reports on and after May 22, 1988, will deduct the revised copayment amount, regardless of the date of service. Claims processed and paid between March 6 and May 22 have been processed using copayment deductions in effect prior to March 1, 1988.

The claims processing system has been corrected to implement the following copayment changes per dates of service as of the May 22, 1988, Remittance and Status Reports:

1. The $30 calendar year copayment limit to physician services is effective with dates of service on or after March 1, 1988, and will be applied per recipient, per billing provider number. A future physicians' bulletin will provide more information regarding the $30 calendar year copayment limit per billing provider number.

   Medicare crossover claims for coinsurance and deductible are included in the $30 limit.

2. Outpatient hospital copayment amounts have increased from $2.00 to $3.00 per visit for dates of service on or after March 1, 1988.

B. Hearing Aid Batteries

The new recipient copayment exemption for hearing aid batteries explained in MAPB-087-038-X, dated December 21, 1987, is effective for dates of service on or after January 1, 1988. However, the current claims processing system deducts copayments according to the date of processing rather than date of service. As a result, all claims for hearing aid batteries processed and paid on the March 6, 1988 Remittance and Status Reports and on Remittance and Status Reports on and after May 22, 1988, will not have copayments deducted regardless of the date of service.

Note: DHSS anticipates that the claims processing system will be corrected in September 1988 to base copayment deductions upon the date of service. EDS will then generate system adjustments for paid claims which do not reflect correct implementation of new copayments for dates of service on and after January 1, 1988. These adjustments will occur automatically and do not require provider action.

XI. MEDICARE NURSING HOME BED CERTIFICATION REQUIREMENTS

Effective July 1, 1988, the Wisconsin Administrative Code HSS 105.09 will require each county to have at least 3 Medicare certified nursing home beds per 1,000 persons aged 65 years or older. The rule allows the DHSS to exempt certain facilities from the Medicare bed certification requirement. A skilled nursing facility (SNF) located in a county with insufficient Medicare beds may request partial exemption from the DHSS if the home has less than 100 beds. Nursing homes applying for a partial exemption must include recommendations regarding the suggested number of beds necessary to meet the demand for Medicare beds in that community, based on their analyses of need and available beds. DHSS will issue a determination regarding its decision to allow partial exemption.

Penalties: If a county has an insufficient number of beds, each SNF without Medicare certified beds is subject to a fine of between $10 and $100 for each day the county continues to be in noncompliance with the requirements.

DHSS is required to:

1. Notify each SNF in a county determined to have insufficient beds of the criteria used to determine insufficiency. This notification must be given 90 days prior to penalty enforcement.

2. Notify each SNF of additional beds needed in a county which drops below the requirement. This notification must be given 90 days prior to penalty enforcement.

County sufficiency levels for minimum nursing home bed certification will be determined by DHSS on an annual basis during September of each year, beginning September 1988.

In October 1988, DHSS will notify all SNFs in any county(ies) which are determined to have insufficient beds. Those SNFs adversely affected will have 90 days to apply for Medicare certification. DHSS will also notify the SNFs which have been exempted, under the rule, from the requirements for those counties.

Penalty enforcement will be conducted according to the administrative procedures, pleadings, and practice requirements under HSS 106.10 (administrative fair hearing rules).

Providers who have questions regarding the new Medicare certification requirements should contact:

Bureau of Health Care Financing
Division of Health
1 West Wilson, Room 250
P.O. Box 309
Madison, WI 53701-0309
(608) 266-2522

ATTACHMENTS

ALL PROVIDER BULLETIN

* *

1. Presumptive Eligibility Card 1

2. Electronic Media Claims. 2-5

3. Family Planning Clinic Replacement Attachment. 6

ATTACHMENT 1
PRESUMPTIVE ELIGIBILITY CARD
(Front and Back)

Front

SECTION V – Temporary ID Card

This card identifies you as being eligible to receive outpatient prenatal care through the Wisconsin Medical Assistance Presumptive Eligibility Program. You may receive these services only from Qualified Providers participating in the Presumptive Eligibility Program. You must present this card to your Qualified Provider **before** receiving care.

EDS FEDERAL

(CUT HERE)

CARD VALIDITY DATES

From: Thru: PE Extension:

ID Number	Eligible Recipient	Birth	Other Ins. (Y/N)	Agency Code

This card entitles the above named individual to receive **outpatient prenatal care** through the Wisconsin Medical Assistance Presumptive Eligibility Program, **from Designated Qualified Providers**, during the time period listed. The individual listed has been determined presumptively eligible for Medical Assistance in accordance with Sec. 49.465, Wis. Stats.

STATE OF WISCONSIN
MEDICAL ASSISTANCE
PRESUMPTIVE ELIGIBILITY PROGRAM
IDENTIFICATION CARD

Back

To the Qualified Provider:

The individual listed on the reverse has been determined presumptively eligible for Medical Assistance in accordance with Sec. 49.465, Wis. Stats. She is entitled to receive WMAP covered outpatient prenatal care from Qualified Providers participating in the Presumptive Eligibility Program beginning on the "From" date and extending through the "Thru" date or the "PE Extension" date, if an extension of presumptive eligibility has been granted and the date and county identifier has been stamped on the card.

To the Patient:

This card identifies you as being eligible to receive outpatient prenatal care through the Wisconsin Medical Assistance Presumptive Eligibility Program. You may receive these services only from Qualified Providers participating in the Presumptive Eligibility Program. You must present this card to your Qualified Provider BEFORE receiving medical care, services or supplies. In order to qualify for Wisconsin Medical Assistance Program benefits after the expiration date of this card, you must apply at your local Social Service office immediately. If you have any questions call:

1-800-362-3002

ATTACHMENT 2

PAPERLESS CLAIMS

DO YOU HAVE A COMPUTER SYSTEM? If so, you can transmit your Medical Assistance claims via a telephone and modem, or send magnetic computer tapes directly to EDS. You can do this without the hassle of purchasing, preparing, storing, and mailing a paper claim form.

THE ADVANTAGES TO YOU ARE:
- Faster processing time improves cash flow
- Accuracy reduces clerical errors
- Saves clerical time in claims preparation
- Time spent in paperwork is reduced

EDS has developed two methods for paperless claims: Tape billing or telephone transmission through electronic claims submission (ECS). Both systems have many advantages and provide options to best suit your individual office needs.

TELEPHONE TRANSMISSION

Purchasing Vendor Software
If you would like a more complete software package including account receivables and payables, or if you want to avoid in-house programming, you may want to purchase ECS software. The software firms listed on page #3 have been tested and approved to offer software to providers for submitting Medical Assistance claims. Feel free to call some of the firms to see what they have to offer you for office automation.

Writing Your Own Software
If you do not want to purchase available vendor software, you may want to develop your own software to customize an existing computer system. Many providers choose this option to enhance their current system from computer generating paper claim forms to telephone transmission. EDS will supply the communication links and electronic claim layouts at no cost.

Obtain EDS Software
EDS has developed a software application for claims entry to be used on IBM personal computers or IBM compatibles such as Compac, Epson, or other computers that use the MS DOS operating system. EDS will distribute an easy-to-use diskette and training manual at no cost.

TAPE BILLING

DO YOU STILL POST YOUR ACCOUNTS MANUALLY? One of the advantages of tape billing is, in addition to your paper Remittance and Status Report (R/S), EDS will provide remittance and status information on magnetic tape. The R/S tape can be sent to you or your tape billing service free of charge.

If you have a computer system that has magnetic tape generating capabilities, EDS will supply the tape record layouts at no cost. If you do not have a computer system that can produce magnetic tape or want to avoid in-house programming, tape billing services are available to bill your Medical Assistance claims. The tape billing services listed on page #4 have been tested and are approved to submit Medical Assistance claims to EDS on magnetic tape.

MORE INFORMATION

If you decide not to utilize the services of software firms or tape billing services, and want the software and/or record layouts provided by EDS, complete the survey on page #2. We look forward to working with you and would be glad to provide information on specific aspects of paperless claims.

ATTACHMENT 2

ELECTRONIC MEDIA SURVEY
PROVIDER QUESTIONNAIRE

Name: ____

Address: ____

____

Medicaid Number: ____________________ **Phone #:** ____________

Contact Person: ____

Type of Service(s) Provided: ________________________________

Estimated Monthly Medicaid Claims Filed: ______________________

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1. Do you currently submit your Medicaid claims on paper? ___YES ___NO

2. Are your Medicaid claims computer generated on paper? ___YES ___NO

3. Do you use a billing service? ___YES ___NO

   If the answer is YES to #2 or #3, please complete the following:

   Name: ____________________ Contact: ____________

   Address: ____________________ Phone #: ____________

   ____

4. Do you have an in-house computer system? ___YES ___NO

   If YES, type of computer system:

   a. Large main frame — Manufacturer: ____________
      (i.e., IBM 360, Burroughs 3800) — Model #: ____________

   b. Mini-Computer — Manufacturer: ____________
      (i.e., IBM System 34, or 36 TI 990) — Model #: ____________

   c. Micro-Computer — Manufacturer: ____________
      (i.e., IBM PC, COMPAQ, TRS 1000) — Model #: ____________

5. Would you be interested in simplifying your claims submission?

   a. ___ YES, via magnetic tape submission

   b. ___ YES, telephone transmission

Return To: E.D.S. Federal Corporation
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009

ATTACHMENT 2

THE FOLLOWING IS A LIST OF APPROVED TAPE BILLING SERVICES FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM.

Tape Billing Service	Address	Contact Person	Telephone	Services/Formats
Alternative Systems, Inc.	6510 Schroeder Road Madison, WI 53711	Charles J. Fiss	(608) ASI-DATA	HCFA 1500, Pharmacy, Nursing Home, UB82
Bertelson Professional Data Service	727 Kenney Avenue Post Office Box 690 Eau Claire, WI 54701	Todd Munden	(715) 832-8212	Nursing Home
Blue Cross Blue Shield	Government Programs 501 W. Michigan Avenue Milwaukee, WI 53201	Carrie Argentati	(414) 226-5764	UB82
Centralized Billing Systems	Division of Data Medic 3636 North 124th Street Milwaukee, WI 53222	Tom Pellizzi	(414) 535-0100	HCFA 1500
County of Sheboygan	615 North 6th Street Sheboygan, WI 53081	Kathi Schultz	(414) 459-3012	Nursing Home
CyCare Systems, Inc.	520 CyCare Plaza Dubuque, IA 52001		(319) 556-3131	HCFA 1500, Pharmacy, Nursing Home, UB82
Datamerica Software, Inc.	7 East Wall Street Ft. Scott, KS 66701	Scott Ogilvie	(316) 223-5340	HCFA 1500
Douglas County Data Processing	Douglas County Courthouse 1313 Belknap Superior, WI 54880	Mark Sandvick	(715) 394-0506	Nursing Home
F. Dohmen Company	Post Office Box 9 Germantown, WI 53022	Dennis Grogan	(414) 255-0022	Pharmacy, Nursing Home
Foxmeyer Drug Company	1919 Northern Wichita, KS 37216	Elain Baker/ Scott Virgin	(316) 529-9242	Pharmacy
Goodwill Industries	6055 North 91st Street Milwaukee, WI 53225	Dan Behrens	(414) 353-6400 (ext. 110)	HCFA 1500, Pharmacy, Nursing Home, UB82
Northwestern Drug Company	2001 Kennedy Street NE Minneapolis, MN 55413	Harry Hedger/ Laura Hagstrom	(612) 331-6550	Pharmacy
Osco Drugs	3030 Cullerton Drive Franklin Park, IL 60131	Judy Gorbach	(312) 455-8300	Pharmacy
Pharmacy Automation Systems	7632 Executive Drive Eden Prairie, MN 55345	David Buhl	(612) 934-9044	Pharmacy, Nursing Home
Professional On-Line Computer	2130 Midland Road Saginaw, MI 48603	Ron Bennett/ Dick Sheldon	(517) 790-0970	HCFA 1500, UB82
RMA, Incorporated	130 W. Wenger Road Englewood, OH 45322	Bill Swartz	(513) 832-0058	Pharmacy
Tape Billing Systems, Inc.	4915 Monona Drive #315 Madison, WI 53716	Marvin Peterson, CPA	(608) 221-4370	Nursing Home, UB82
3-PM/McKesson, Inc.	3881 Schoolcraft Livonia, MI 48150	Paula Unold	(313) 427-2000	Pharmacy
Total Computer Systems, Ltd.	4488 HWY 73 Post Office Box 86 Deerfield, WI 53531	Lloyd L. Radloff	(608) 764-5484	Nursing Home
Turnaround-Pharm Central	2045 Midway Drive Twinsburg, OH 44087	Rose Galish	(216) 425-3241	Pharmacy
Viking Computer Services	2411 Nicollet Avenue So. Minneapolis, MN 55404	Elliot Krelitz	(612) 871-4430	Pharmacy, Nursing Home

ATTACHMENT 2

THE FOLLOWING IS A LIST OF SOFTWARE FIRMS FOR ELECTRONIC CLAIMS SUBMISSION (ECS) APPROVED BY THE WISCONSIN MEDICAL ASSISTANCE PROGRAM.

Software Firms	Address	Contact Person	Telephone	Services/Formats
Benchmark Computer Systems	17500 W. Liberty Lane New Berlin, WI 53146	Dana L. Billings	(414) 784-5350	Nursing Home
Calyx Corporation	150 N. Sunnyslope Road #375 Brookfield, WI 53005	Barbara Taylor	(800) 558-2208	HCFA 1500
Care Computer Systems	636 120th Avenue NE Post Office Box 1408 Bellevue, WA 98009	Sean Boltman	(206) 451-8272 1-800-426-2675	Nursing Home
Columbia Data Processing Corporation	119 W. Conant Street Post Office Box 585 Portage, WI 53901	Alan W. Glick	(608) 742-2103/ 742-4000	Nursing Home, UB82
Comp Systems, Inc.	QS1 Pharmacy System 103 W. Vadnais Blvd. St. Paul, MN 55127	Laurie Lundeen	(800) 328-4827 (ext. 2080)	HCFA 1500, Pharmacy
CyCare Systems, Inc.	520 CyCare Plaza Dubuque, IA 52001		(319) 556-3131	HCFA 1500, Pharmacy, Nursing Home, UB82
Datamerica Software, Inc.	7 East Wall Street Ft. Scott, KS 66701	Scott Ogilvie	(316) 223-5340	HCFA 1500
Goodwill Industries	6055 North 91st Street Milwaukee, WI 53225	Dan Behrens	(414) 353-6400 (ext. 110)	HCFA 1500, Pharmacy, Nursing Home, UB82
Orion Systems, Inc.	3350 Scott Blvd. #34 Santa Clara, CA 95054	M. Kessler	(408) 727-9900	HCFA 1500
Osco Drugs	3030 Cullerton Drive Franklin Park, IL 60131	Judy Gorbach	(312) 455-8300	Pharmacy
Tape Billing Systems, Inc.	4915 Monona Drive #315 Madison, WI 53716	Marvin Peterson, CPA	(608) 221-4370	Nursing Home, UB82
Viking Computer Services	2411 Nicollet Avenue So. Minneapolis, MN 55404	Elliot Krelitz	(612) 871-4430	Pharmacy, Nursing Home
Software Banc, Inc.	3121 W. Wisconsin Avenue Milwaukee, WI 53208	Craig Evans	(414) 342-4900	HCFA 1500

ATTACHMENT 3

FAMILY PLANNING CLINIC REPLACEMENT ATTACHMENT

* *

The following is a replacement for Attachment 4 of Family Planning Clinic MAPB-087-006-P, dated 09/01/87.

ATTACHMENT 4
FAMILY PLANNING CLINIC SERVICES

* *

PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
1	3	Office

TYPE OF SERVICE (TOS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	9	Other (including family planning)
5	5	Diagnostic Lab (total)
T	X	Diagnostic Lab (professional)