



Medicaid Information Technology System

State & Local Government Solutions

Medicaid Information Technology System (MITS)

Reimbursement Agreements Participant Guide

September 8, 2010

**HP Enterprise Services
Suite 100
50 West Town Street
Columbus, OH 43215**

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Course Overview

Overview

The goal of this course is to provide you with the skills required to perform tasks related to reimbursement agreements in Ohio MITS.

You will learn how to configure and maintain reimbursement agreement rules.

Prerequisites

Before taking this course, you must complete the following courses:

- Introduction to MITS
- Benefit Plan Administration Overview
- Benefit Classifications
- Recipient Plans
- Provider Contracts

Objective(s)

After completing this course you should be able to:

- View an existing reimbursement rule
- Create and maintain reimbursement rules
- Create a pricing indicator
- Create a rate type
- Create a benefit adjustment factor

Agenda

Topic	Time
Welcome and Introductions	5 minutes
Introduction to Reimbursement Agreements	25 minutes
Introduction to Rules	25 minutes
Break	10 minutes
Searching for Rules	25 minutes
Reimbursement Agreement Parameters	15 minutes
The Save Process	10 minutes
Creating and Saving Reimbursement Rules	20 minutes
Break	10 minutes
Rule Options	15 minutes
Updating/Modifying Rules Data	15 minutes
Introduction to Rule Diagnosis Editing	10 minutes
Configuring Rule Diagnoses	20 minutes
Lunch	50 minutes

Agenda (Continued)

Topic	Time
Introduction to Rule Modifier Editing	10 minutes
Configuring Rule Modifiers	20 minutes
Introduction to Removing Rules	10 minutes
Excluding/Inactivating Rules	15 minutes
Break	10 minutes
Introduction to Conflict Report Errors	10 minutes
Correcting Conflict Report Errors	15 minutes
Related Data Maintenance	25 minutes
Adding a Pricing Indicator	10 minutes
Adding a Rate Type	10 minutes
Adding a Benefit Adjustment Factor	15 minutes
Review	5 minutes

Introduction to Reimbursement Agreements

Overview

Reimbursement rules are the criteria and restrictions for a billable service that determine which pricing method to use to determine provider reimbursement.

The primary purpose of reimbursement agreement rules is to identify the criteria to determine specific actions. The primary actions of a reimbursement rule are:

- Pricing Indicator
- Rate Type
- Adjustment Factor
- Edits
- Modifiers

Importance of Reimbursement Agreements

Reimbursement agreements are important because they perform the following, vital functions:

- Identify State-specific pricing policies, methods, and rate types
- Define the rules that contain the criteria to price a claim

Reimbursement Agreements Panel

Reimbursement agreement rules are based upon OHP policy. Configuration analysts can enforce OHP policy by adding and maintaining reimbursement rules through the graphical user interface in MITS.

Note the components in the **Reimbursement Agreement** panel below:

- 1) **Reimbursement Agreement** link
- 2) **Reimbursement Contract Search** field and **Search Results** list
- 3) **Directive Version** drop-down list
- 4) Medical classification search feature and tree structure

The screenshot displays the MITS interface for Reimbursement Agreements, divided into four numbered sections:

- Section 1:** The 'Benefit Administration' menu on the left has 'Reimbursement Agreement' selected. A red box highlights this menu item, with a red '1' in a circle next to it.
- Section 2:** The 'Reimbursement Agreement' window shows a search field for 'Reimbursement Contract' and a 'Search Results' table. A red box highlights the search field and the table, with a red '2' in a circle next to the window title.

Reimbursement Contract	Description	Effective Date	End Date	Inactive Date
ALCRX	ODADAS Contract	01/01/1900	12/31/2299	12/31/2299
ALWV	ODA Assisted Living	01/01/1900	12/31/2299	12/31/2299
AMBLC	Ambulance Contract	01/01/1900	12/31/2299	12/31/2299
ANES	Anesthesia Contract	01/01/1900	12/31/2299	12/31/2299
APN	Advanced Practice Nu	01/01/1900	12/31/2299	12/31/2299
ASC	ASC Contract	01/01/1900	12/31/2299	12/31/2299
BLDG	Building and Wing Id	01/01/1900	12/31/2299	12/31/2299
CBCLT	Transportation	01/01/1900	12/31/2299	12/31/2299
CHIRO	Chiropractor Contrac	01/01/1900	12/31/2299	12/31/2299
CHOIC	Choices Wvr Contract	01/01/1900	12/31/2299	12/31/2299
- Section 3:** A dropdown menu for '*Directive Version' is shown, with a red box and a red '3' in a circle next to it.
- Section 4:** A search interface for medical classification. The search field contains 'Procedure' and a 'Find' button. Below is a tree view showing 'Procedures' > 'Chiropractic Svcs' > 'All Procedures' > 'CPT Codes'. A red box highlights the search field and tree, with a red '4' in a circle next to the window title. Red arrows point to 'CPT Codes' and '544 DOS' with explanatory text:
 - Right-click to see the rules summary/restriction choices
 - Right-click to see the details of this specific rule

The Pricing Functions of MITS

MITS processes the various claims types using the following pricing methods/schedules:

Using this pricing function...	MITS...
Professional Claims Pricing	Uses procedure codes and modifiers to price each service detail on professional claims. Functions within Professional Claims Pricing commonly include Max Fee and Rate type.
Max Fee	Maintains a Max Fee table, or schedule, for each procedure code (or code and modifier combination.) OHP staff maintains Max Fee data based on OHP pricing policy.
Rate Type	Allows different rates to be applied for a single benefit at the same point in time.
Customary Charge Pricing	Maintains the Usual Customary Charge (UCC) rates for each provider.
ASC Pricing	Uses rates for pricing Ambulatory Surgical Center procedures. CMS establishes the procedures in these payment groups and updates them annually.
Flat Fee Pricing	This is not applicable to OHP.
Provider Nursing Home (NH) Rates Pricing	Prices claims using these rates received through an electronic interface to the provider subsystem.
Hospital Rates Pricing	Maintains percent of charge rates for hospital outpatient and inpatient services and DRG rates for hospital inpatient services. These Hospital Rates, along with Pricing Indicators, determine the price to pay on an adjudicated hospital claim.
Pricing Indicators	Uses settings defined by a pricing analyst to accommodate different pricing methods, for example: default, percent of charge, prior authorization (PA) pricing, manual pricing, and outpatient bundled pricing.
Benefit Adjustment Factors	Alters payment amounts based upon specific criteria.

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

What MITS function defines the rules that contain the criteria to price a claim?

- A. Provider Agreements
- B. Benefit Classification
- C. Reimbursement Agreements
- D. Recipient Plans

The **Reimbursement Agreement** panel contains all of the following elements, except:

- A. Links to Reimbursement Contracts
- B. Tree listing benefit classifications
- C. Drop-down list containing directive versions
- D. Pricing Tables

MITS processes claims using only the Usual Customary Charge (UCC) table.

- A. True
- B. False

Summary

In this lesson you learned about the function and importance of reimbursement agreements.

You should be able to identify the MITS panels used for reimbursement rule management.

Introduction to Rules

Overview

In this lesson, you will learn about rules, rule directives, types of business rules, the tree structure, the rule summary, and rule categories.

Rules as Policy

Business rules represent user requirements usually expressed as statements about business behavior. In general, rules describe when to cover a particular service and the parameters that surround the coverage.

You can configure a rule to define coverage for places of service, claim types, recipient plans, provider contracts, types of bills, diagnoses, provider types or specialties, modifiers, occurrence codes, and condition codes. Examples of rule parameter changes you can make include the following:

- Include parameters
- Exclude parameters
- Bypass parameters

It is important to understand that rules are not put in place to deny a claim. In fact, the opposite is true. You create rules to enable payment of a claim.

Business Rules usually originate from state policy and the National Code List. They could also come from a provider inquiry.

Rules enable the State to:

- Identify, refine, and maintain the business rules needed to manage Medicaid requirements
- Group services logically, according to recognized medical standards and incorporate rules that have been set up within the classification
- Configure rules that parallel their policies — written as broadly or as detailed as needed

Rule Directives

In MITS, you associate business policy changes to rules. **Directives** tie the rules to the policy changes. Directives track individuals that request, authorize, and implement a change to rules and they allow you to promote rules and other pertinent reference data to production status using a directive ID and version. A **Directive Type** identifies each directive. Directive Types are custom for OHP and include Ohio Administrative Code (OAC), Ohio Revised Code (ORC), Code of Federal Regulations (CFR), Senate Bill (SNB), and House Bill (HSB).

A **Directive Version** controls updates to the original directive. If you discover an error after copying the original directive version to the production environment, you may add another directive version. Versions allow you to organize all policy changes related to the original change order in one directive. Versions also allow you to determine if additional changes are needed after promoting the original directive.

Types of Rules

For MITS to pay a claim, one of each of three rule types **must** exist: recipient plan, provider contract and reimbursement rules.

Rule Type	Description
Recipient plan rule	Determines the services for which a Medicaid recipient is eligible. These rules are based on the defined benefit plans and hierarchies.
Provider contract rule	Determines if a provider is authorized to perform, refer, or bill for a particular service. These rules are based on combinations of provider types and specialties.
Reimbursement agreement rule	Defines pricing methodologies and adjustment factors to apply to a given service.

These three rules combined define who receives a service, which providers perform, refer, or bill a service, and what reimbursement methodologies apply to a service.

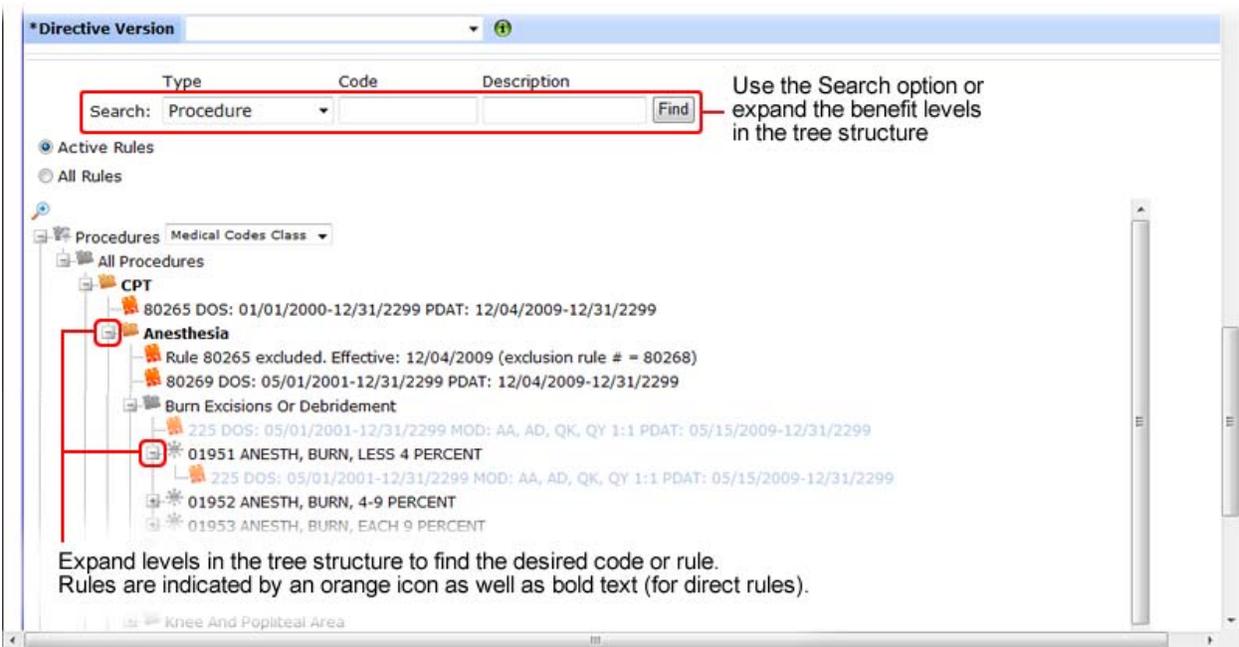
Another rule you might consider is for Other Insurance (OI), also referred to as Third Party Liability. The OI plan includes a list of services covered by the other carriers. OI plans might also cover services that the State Healthcare program covers. During the adjudication process, MITS compares service billed to services covered in the OI plan. If the OI plan covers a service, but the carrier does not make a payment then MITS denies the claim. If the service is not covered in an OI plan, then MITS processes the claim under Medicaid. Medicaid is always the payer of last resort.

Optional rule types may exist that also affect adjudication decisions based on the recipient/provider/service combination.

Example: Copay rules apply to some claims. Some recipients are not required to make a copay payment. Certain benefit groups and ages are exempt. Copay rules define the conditions under which a provider must collect a specified patient obligation or payment for specified services.

Tree Structure

In MITS, rules apply directly to the benefits, which are organized logically in a **tree structure**.



Many groups are divided into subgroups. To locate a group, subgroup, or a specific benefit or rule, continue to open the benefits tree by clicking the '+' symbols.

Each benefit type has its own tree structure. To navigate the structure, follow these guidelines:

- Click the '+' symbol next to the benefit coverage to expand the panel.
- Scroll to the bottom to view the entire list.
- Click the '+' symbol next to a benefit type (Drugs, Revenue Codes, DRGs, Diagnoses, Procedures or ICD-9 Procedures) to expand the available groups found under these sections.
- Click the '+' symbol next to the next level to expand the benefit groups and display another level of subgroups.

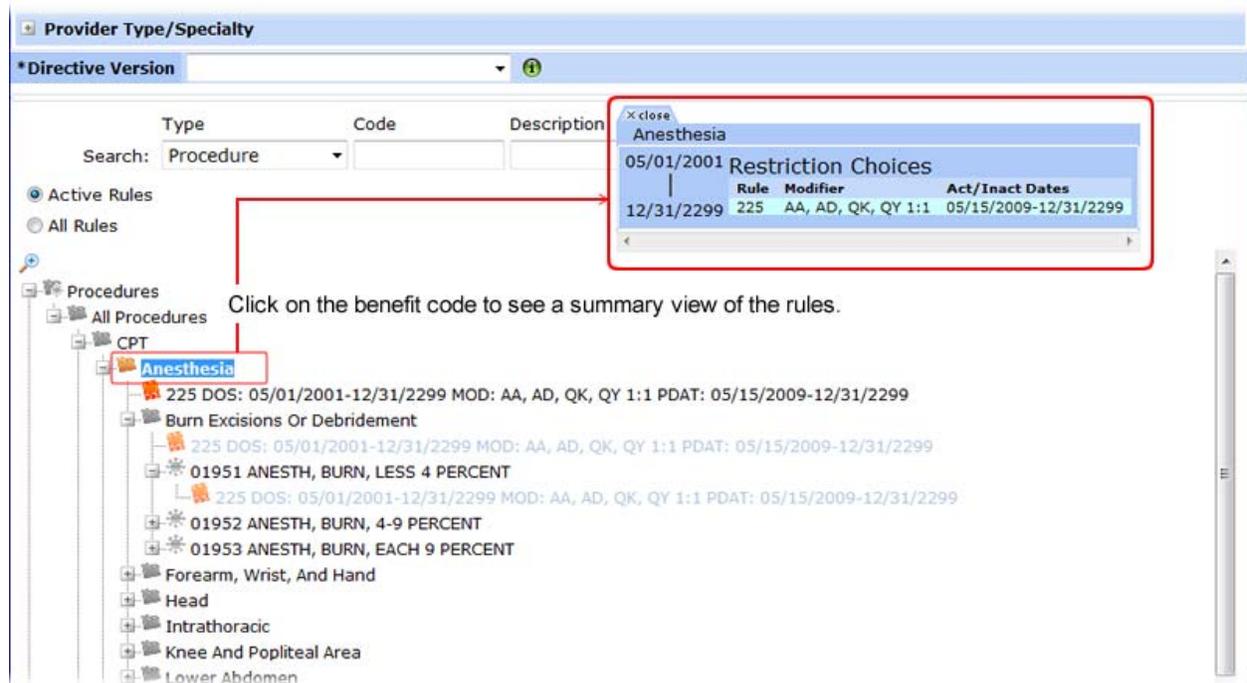
Review the table for more information on the benefit types, codes, and sources of information:

Benefit Type	Code Type and Source of the information
Procedures	CPT (American Medical Association) HCPCS (The Medical Management Institute)
Drugs	Generic Therapeutic Class Specific Therapeutic Class HIC4 GCN NDC
Diagnoses	CDC (Centers for Disease Control)
Revenue Codes	UB04 - (National Uniform Billing Committee)
ICD-9 Procedures	ICD9 Surgical Procedures - CDC
DRG	CMS - Medicare Code Editor

Rule Summary

You can view high-level information about rules quickly by viewing the **rule summary (restriction choices)**. To display the rule summary, click the benefit or benefit group. If a rule exists, the rule summary displays the rule, the effective and activation dates, as well as any restrictions.

When making rule changes, monitor the rule summary **before and after** you save your changes to determine if any conflicts or issues exist related to your changes.



In the example, only one rule (225) applies to Anesthesia. If there are any restrictions, they display in the rule summary.

The rule summary components vary depending on what editing options the rule contains. Review the rule summary components shown in this simple example.

Column/field	Description
Dates	Date range in which the benefit code is active
Rule #	Rule ID number
Modifier	The modifiers that affect claim adjudication
Act/Inact Dates	Date range in which the rule is active

Best practice: View the rule summary frequently to monitor rule creation and maintenance.

Rule Categories

There are two categories of rules: direct and inherited. Review the table for a description and example of each.

Direct Rules	Inherited Rules
A direct rule applies to an individual service code (benefit) that enforces the State policy. Direct rules can exist on classification groups as well.	An inherited rule applies to the group level and cascades down to all benefits associated with a group. These rules are inherited from a higher level. When you create a rule at the group level, all the codes in that group inherit that rule.
Example: If one procedure code requires a specific Place of Service, then create a direct rule at the benefit level for that one procedure code.	Example: If all CPT office and outpatient evaluation and management procedures require the same pricing methodology, create one rule at the benefit classification group level (Office Or Other Outpatient Services), rather than creating multiple rules for each service code within that classification.

The screenshot shows the MITS software interface with the following elements:

- Provider Type/Specialty:** CNV2009 v1 Release SYSTEM IMP
- Search:** Procedure
- Active Rules:** Selected
- Medical Codes Class:** Anesthesia
- Direct rule (bolded and active):** 225 DOS: 05/01/2001-12/31/2299 MOD: AA, AD, QK, QY 1:1 PDAT: 05/15/2009-12/31/2299
- Inherited (cascaded rule) (faded and grayed out):** 01951 ANESTH, BURN, LESS 4 PERCENT; 01952 ANESTH, BURN, 4-9 PERCENT; 01953 ANESTH, BURN, EACH 9 PERCENT

In the example, rule 225 was created at the Anesthesia group level. It is also a valid rule for each procedure code within that group. Inherited rules are faded at the procedure code level. MITS uses rule 225 to edit any claims that contain CPT codes in the Anesthesia group.

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

For MITS to pay a claim, one of each of three rule types **must** exist: a Recipient Plan, Provider Contract, and a Reimbursement Agreement.

- A. True
- B. False

This type of rule specifies the services a Medicaid Recipient is eligible for:

- A. Other Insurance rule
- B. Reimbursement Agreement rule
- C. Provider Contract rule
- D. Recipient Plan rule

A rule that applies to all codes (benefits) within a group is called a(n):

- A. Optional rule
- B. Inherited rule
- C. Waterfall rule
- D. Direct rule

Rules are put in place to deny claims.

- A. True
- B. False

A ____ links a business rule to the source of the policy:

- A. Initiative
- B. Rule Category
- C. Directive

Summary

In this topic, you learned about the rules-based engine, rule directives, types of business rules, the tree structure, the rule summary, and rule categories.

Searching for Rules

What

In this topic, you will learn how to search for and view rules in the Reference subsystem.

Who

Provider services analyst, policy analyst, configuration analyst, claims analyst, and other appropriate staff may perform this task.

When

You perform this task when you are researching rules for claims research or identifying changes in policies/directives.

Relevance

The Benefit Administration panels provide the ability to maintain and add business rules in one location, thus allowing you to identify gaps or overlaps in coverage.

Requirements

To search for a rule, you need one or more of the following:

- A benefit group (i.e. provider contract, a recipient plan, or a reimbursement agreement),
- A benefit code (such as a procedure that a provider contract can bill).
- A claim or a specific rule or code that you want to research
- A new policy directive that you want to research

Guidelines

Each rule can be configured to include, exclude, or bypass parameters when defining coverage for variables such as places of service, claim types, recipient plans, provider contracts, types of bill, diagnoses, provider types or specialties, modifiers, occurrence codes, and condition codes.

All rules for a specific recipient plan or provider contract must exist on the same classification for a given benefit. The rule authoring panels locks a recipient plan or provider contract to the **first** benefit classification where a rule is authored.

How To

Follow these steps from the MITS home page to view and search for reimbursement agreement rules in the Reference subsystem:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Reimbursement Agreement .						
4	Select the provider contract with these instructions: <table border="1" data-bbox="371 749 1375 1136"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the provider contract in the search field. b. Click search. Note: The matching provider contract will display (or a list if you only typed the first letter). </td> </tr> <tr> <td>Navigate the search results list</td> <td> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).	Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.
TO:	THEN:						
Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).						
Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.						
5	Find the benefit code in the medical classification with these instructions: <table border="1" data-bbox="371 1241 1375 1675"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search the medical classification</td> <td> a. Select the desired type from the Type (i.e., Procedures, HCPCS, etc.) drop-down list. b. Enter the appropriate code in the Code field. c. You can search with the Description field, as well (if this would be effective). d. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service. </td> </tr> </tbody> </table>	TO:	THEN:	Search the medical classification	a. Select the desired type from the Type (i.e., Procedures, HCPCS, etc.) drop-down list. b. Enter the appropriate code in the Code field. c. You can search with the Description field, as well (if this would be effective). d. Click Find .	Navigate the tree	a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service.
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Navigate the tree	a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service.						
6	Click the benefit/service code level to view the rule summary.						
7	Click the rule to view the rule edit panel.						

Success

You have successfully completed this task when the rule displays in the window.

Practice

Search for reimbursement agreement rules. (We will not discuss all the rule options here, just look at basic rule search):

- Reference>Benefit Administration>Reimbursement Agreement>
- Type V and click search - select Vision.
- Search for procedure code 99211.
- What is the difference between rules 75845 and 75846?
- Expand tree view under Vision>Procedures and find which procedure code has a rule other than 75845 and 75846.

Summary

In this topic, you learned how to search for rules in MITS.

Q&A

Save Process

Overview

Before you learn how to create or modify a rule in the Reference subsystem, it is important to understand two concepts:

- Three-step save process
- Checks and validations the system does during the save process

System checks

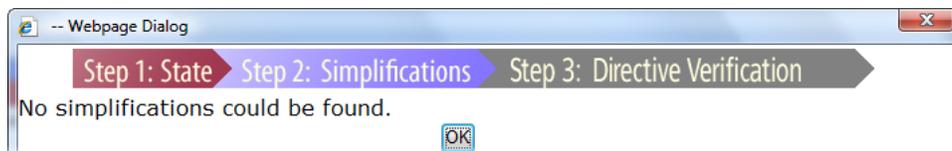
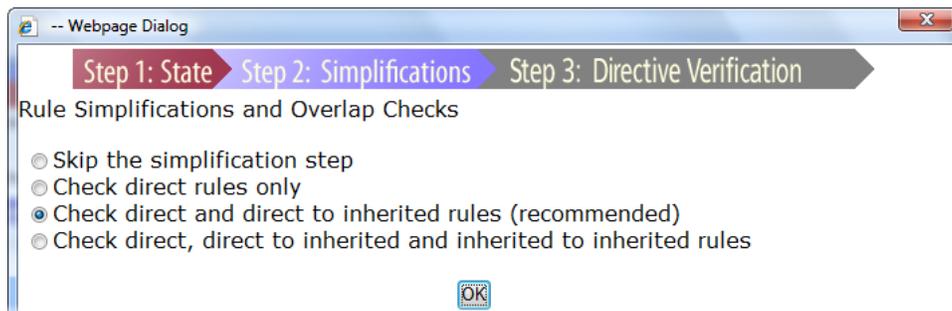
When you create a rule and attempt to save your changes, MITS launches a three-step save process to look for rule conflicts or errors. The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen directive and version. The steps are described below:

- 1) The **State** step identifies conflicting rules. When this happens, the claim engine is unable to process the claim properly. The system does not save changes until you correct or remove the ambiguity. Click Cancel to return to the previous screen to make the appropriate changes. Refer to the Summary window to determine how to correct the conflict.
- 2) The **Simplification** step checks for ways to make the rules work together and combines rules to simplify the data and rules. If MITS finds conflicting or overlapping dates, the dates display. During this step, you can save the rule “as is” or cancel the save and return to the previous window to make the appropriate changes.
- 3) The **Directive Verification** step validates the chosen directive and version. At each step, the system allows you to back out of the Save process and correct any problems it finds.

Three Steps

Once all three steps are complete, if no errors or conflicts exist, MITS saves the changes and displays a save validation message. Review the windows associated with the three-step save process:

To proceed through the three-step save process, click **OK** on each window to continue. You can cancel the save at any point that the system finds a conflict, if desired.





Conflicts

If the system finds a conflict, you can click **Cancel Save** and make revisions.

Step 1: State Step 2: Simplifications Step 3: Directive Verification

Rule Simplifications and Overlap Checks

Procedures - HCPCS - National Codes Established for State Medicaid Agencies - T2001 N-ET; PATIENT ATTEND/ESCORT

ID	Modifier
76079	DD, DE, DG, DH, DI, DJ, DN, DP, DR, ED, EE, EG, EH, EI, EJ, EN, EP, ER, GD, GE, GH, GI, GN, GP, GR, HD, HE, HG, HH, HI, HJ, HN, HP, HR, ID, IE, IG, IH, II, IJ, IN, IP, IR, JD, JE, JH,
76453	DS, ES, GG, GJ, GS, HS, IS, JG, JJ, JS, NS, PS, RR, RS, SD, SE, SG, SH, SI, SJ, SN, SP, SR, SS, US 1:1 and U6 0:1 and U1, U2 0:1
split of new1	** 0:0

The 2 rules below overlap. However because of the types of variables they contain they cannot be converted to rules that do not overlap

- 76079 DOS: 10/01/2003-12/31/2299 MOD: DD, DE, DG, DH, DI, DJ, DN, DP, DR, ED, EE, EG, EH, EI, EJ, EN, EP, ER, GD, GE, GH, GI,
- split of new1 DOS: 10/01/2003-12/31/2299 MOD: ** 0:0 PDAT: 07/22/2010-12/31/2299

12/31/2299 It is recommend that you cancel the save and modify these rules so that they do not overlap. Click **Cancel Save** to make revisions.

OK **Cancel Save**

When you cancel a save, you can make revisions in the edit panel; or you can delete and start over. You will only see the **Delete Rule** option when a rule has not yet been saved. Also, the rule is given a temporary name (new) instead of a system-assigned numeric.

Directive Version CNV2009 v1 Release SYSTEM IMP ⓘ

Type	Code	Description
Search: Procedure		Find

Active Rules
 All Rules

Procedures

- All Procedures
 - HCPCS
 - 156 DOS: 07/01/2006-12/31/2299 AGE: 21-999999 BPTS: 93/930 PDAT: 05/04/2009-12/31/2299
 - new2 DOS: 01/01/2000-12/31/2299 AGE: 35-999999 BPTS: 93/930 PDAT: 07/29/2010-12/31/2299
 - Temporary National **Delete Rule**
 - 156 DOS: 07/01/2006-12/31/2299 AGE: 21-999999 BPTS: 93/930 PDAT: 05/04/2009-12/31/2299
 - new2 DOS: 01/01/2000-12/31/2299 AGE: 35-999999 BPTS: 93/930 PDAT: 07/29/2010-12/31/2299
 - T2031 ASSIST LIVING WAIVER/DIEM
 - T2038 COMM TRANS WAIVER/SERVICE

Drugs

Right-click and delete the rule to start over. Since the rule was not saved, it is named new instead of a system-assigned numeric.

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

Which of the 3 steps identifies conflicting rules?

- A. Simplification step
- B. Directive Verification step
- C. State step

Which of the 3 steps checks for ways to make the rules work together and combines rules to simplify the data and rules?

- A. Simplification step
- B. Directive Verification step
- C. State step

Which of the 3 steps validates the chosen directive and version?

- A. Simplification step
- B. Directive Verification step
- C. State step

Summary

In this topic you learned about the three-step save process.

Reimbursement Agreement Parameters

Overview

In this lesson, you will learn about the following parameters that affect how a pricing rule pays a benefit:

- Pricing Indicator
- Rate Type
- Benefit Adjustment Factor

These parameters, plus the service – such as procedure or revenue code – determine the specific rate to apply.

Rate Type

The rate type parameter allows the pricing table to hold different rates for the same benefit, such as a procedure, at the same time.

Here are two examples of reasons to create a new rate type:

- You pay a physician differently for an identical procedure on two different claims because different conditions exist which warrant a different rate. For example, the provider submits one claim where the code includes a modifier indicating prenatal care.
- You pay for a vaccination for an adult at \$14.00, but for the same vaccination for a child, you pay \$10.00.

The image illustrates the location of the **Rate Type** field.

The screenshot displays a software interface with several sections:

- Created By:** [Field]
- Created On Config:** NA
- Last saved via Directive Version:** [Field]
- Eff/End Dates:** 01/01/2000 | 12/31/2299
- Claims Submission Dates:** 01/01/2000 | 12/31/2299
- Admission Date:** [Field]
- Age:** 0 | 999999
- Act/Inact Dates:** 07/27/2010 | 12/31/2299
- Discharge Date:** [Field]
- Quantity:** 0 | 999999
- Rate Type:** [Dropdown menu, highlighted with a red box]
- Pricing Indicator:** [Dropdown menu]
- Medical Review:** No
- Gender:** [Field]
- Prior Auth:** [Field]
- Bed Size:** [Field]
- Out of State Provider:** [Field]
- Adjustment Factor Sequence:** [List of factors with green status icons]
- Available Adjustment Factors:**
 - 1028 (\$15) - Place of Service
 - 1030 (\$25) - Place of Service
 - 1032 (\$50) - Place of Service
 - 1034 (140%) - Special provisio
 - 1036 (85%) - APN modifiers SA
 - 1042 (50%) - Multiple BAFs -
- County Editing:** No
- Patient Status Editing:** No
- Type of Bill Editing:** No
- Place of Service Editing:** No
- Level of Care Editing:** No
- Claim Type Editing:** No
- Recipient Plans Editing:** No



All reimbursement rules should have a rate type assigned, even if that rate type is "default."

Pricing Indicator

The MITS pricing indicator function specifies the payment methodology to be applied when determining the payment to a provider for a service.

Examples of pricing indicator values are:

- **MAXFEE** Procedure Code Max Fee
- **HOSPCE** Hospice
- **BILLED** Pay as Billed
- **ANESTH** Anesthesia

The image illustrates the **Pricing Indicator** field.

The screenshot displays a web-based form for configuring reimbursement agreements. The 'Pricing Indicator' field is highlighted with a red border, and its dropdown menu is open, showing a list of options. The options include:

- ANESTH Anesthesia
- ASC Ambulatory Surgery Center
- BILLED Pay as Billed
- DMEPA DME Repair - over \$100
- DRG Diagnosis Related Group
- DRG_OL Special DRG Outlier
- DRGPDM IP DRG trans/par eligibl
- ENPRIC Encounters - price at \$0
- FLTFEE Revenue Code Flat Fee
- HHPDN Home Health - PDN
- HOSPCE Hospice
- IODBUS MRDDIO Waiver daily un
- IPBPCT Inpatient Cost to Charge
- IPXOVR Inpatient Xover Part A
- IPXVRC Part C Inpatient Xovers
- LTCLOC LTC Lvl of Care per diem
- LTHSPC Hospice LTC 95% LTC PC
- MANUAL Manually Priced
- MAXFEE Procedure Code Max Fee**
- MAXFLT Max Fee Flat Rate (less)
- MXFLT2 Max Fee Flat Rate (max)
- MXFSSA OH MAXFEE SISTER AGE
- NFXOVR NF Crossover (Part A)
- NOPRIC Price at \$0 w/o denying
- OP50PC Oupatient price at 50%
- OP60PC Oupatient price at 60%
- OP65PC Oupatient price at 65%
- OP69PC OP unlst srg 69% line ch
- OP70PC OP radiology 70% line ch

Other visible fields in the form include:

- Created By:** [Text Field]
- Created On Config:** NA
- Last saved via Directive Version:** [Text Field]
- Eff/End Dates:** 01/01/2000 to 12/31/2299
- Claims Submission Dates:** 01/01/2000 to 12/31/2299
- Admission Date:** [Text Field]
- Age:** 0 to 999999
- Act/Inact Dates:** 07/27/2010 to 12/31/2299
- Discharge Date:** [Text Field]
- Rate Type:** [Dropdown]
- Quantity:** 0 to 999999
- Gender:** Both
- Prior Auth:** No
- Bed Size:** 0 to 999999
- Out of State Provider:** Both
- Medical Review:** [Text Field]
- Adjustment Factor Sequenc** [List of factors with arrows]
- County Editing:** No
- Patient Status Editing:** No
- Type of Bill Editing:** No
- Place of Service Editing:** No
- Level of Care Editing:** No

Benefit Adjustment Factor

The Benefit Adjustment Factor (BAF) function provides the ability to alter an existing allowed benefit amount by a set percentage, a series of percentages, or a dollar amount in order to increase or reduce the allowed amount by the percentage or dollar amount assigned.

This type of adjustment works in conjunction with pricing methodologies to allow you to alter a rate based upon multiple, conditional criteria without having to create new rates.

The image below illustrates the fields used to assign benefit adjustment factors.

Adjustment Factor Sequence

Adjustment Factors Assigned		Available Adjustment Factors
1035 (85%) - APN modifiers SA, \$	<div style="display: flex; flex-direction: column; align-items: center; gap: 5px;"> <G G> >G G< </div>	1028 (\$15) - Place of Service (^ 1030 (\$25) - Place of Service (^ 1032 (\$50) - Place of Service (^ 1034 (140%) - Special provisio 1042 (50%) - Multiple BAFs - N 1046 (25%) - Transportation n ^

3 View your selection(s) here
2 Click appropriate arrow icon
1 Select the adjustment factor(s).



This field only operates in "include" mode.

Benefit Adjustment Factors vs. Processing Modifiers

It is important to understand that benefit adjustment factors function differently than processing modifiers. Benefit adjustment factors modify the rate only in certain circumstances. Processing modifiers modify the rate in **every** circumstance, across **all** contracts.

Let's look at a scenario and discuss the results of using a BAF as opposed to the results of using a processing modifier:

Scenario: You receive a directive that states that you are to pay only 85% of the normally-allowed amount for a specific procedure when **both** of the following conditions are true:

- 1) A nurse practitioner performed the procedure
- 2) The place of service was an inpatient, outpatient, or ER hospital setting

Using a benefit adjustment factor – If you create a rule that contains a combination of these three rule variables...

- "SA" modifier indicating that the service was performed by nurse practitioner
- Place of service indicators for inpatient, outpatient, or ER hospital settings
- Benefit adjustment factor = 85%

...then, the rule will adjust the allowed amount by the specified percentage only if **all** of the required criteria exist.

Using a processing modifier – If you set up a processing modifier in the **Modifier** panel to check for the existence of the nurse practitioner modifier ("SA"), then it will adjust the rate based only on the existence of the modifier. The processing modifier will not test for the place of service variable. Also, the processing modifier will apply the rate modification across **all** contracts where the SA modifier is allowed.

Recommendation: For this scenario, you should set a benefit adjustment factor in the rule, to ensure that the adjustment occurs based upon **all** of the required criteria.

Rules Summary (Restriction Choices)

The **Rule Summary (Restriction Choices)** panel provides a quick summary view of the rules that apply to a benefit.

To view the applicable rules, click the benefit code from the list. If a rule exists, the panel displays the rule, showing the applicable restrictions.

The image illustrates the rules summary for a reimbursement rule.

Surgery								
Restriction Choices								
	Rule	Modifier	Claim Type	Place of Service	Act/Inact Dates	Pricing Indicator	Rate Type	Adjustment Factor
01/01/2000 12/31/2299	i24000		B		01/18/2010-12/31/2299	PRXOVR	DEF	
	24007	(SA, SB, UC) 0:4	(B)		01/18/2010-12/31/2299	MAXFEE	DEF	
	24009	SA, SB, UC 1:1 and (SA, SB, UC) 0:3	(B)	21, 22, 23, 51	01/18/2010-12/31/2299	MAXFEE	DEF	(1036 (85%) - APN modifiers SA, SB, and UC in a h)
	24008	SA, SB, UC 1:1 and (SA, SB, UC) 0:3	(B)	(21, 22, 23, 51)	01/18/2010-12/31/2299	MAXFEE	DEF	

Column Name	Description
Effective Date for the procedure (Column is not labeled in the image.)	Date range in which the benefit code is active
Rule	The rule ID number. Note: Rule IDs that begin with 'I' indicate that the rule was inherited from a higher level.
Modifier	The modifiers that affect the pricing. Note: Modifiers that are <i>italicized</i> and in parenthesis indicate that the modifiers must not exist in order for that rule to be applied.
Claim Type	The code indicating the claim type. Note: Codes that are <i>italicized</i> and in parenthesis indicate that the modifiers must not exist in order for that rule to be applied. For example, if B means "Crossover", then (B) means not a crossover.
Place of Service	Indicates the places where the procedure must, (<i>or must not</i>) be performed in order for the rule, or specific parameters of the rule, to apply. For example: Whether the procedure was performed in a hospital, may determine whether a specific rule applies.
Act / Inact Dates	Date range in which the rule is active.

Column Name	Description
Pricing Indicator	The pricing indicator code that applies to the specific rule
Rate Type	The rate type applies to the rule. Note: Def = Default
Adjustment Factor	Indicates whether an adjustment factor will apply to claims meeting the criteria of the rule.  In other panels, this is sometimes called a "Benefit Adjustment Factor."

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

Which function specifies the payment methodology to be applied when determining the payment to a provider for a procedure?

- A. Benefit Adjustment Factor
- B. Rate Type
- C. Pricing Indicator
- D. Procedure Modifier

Which of the following are valid reasons to create a new rate type? (Select all of the correct answers)

- A. An outpatient hospital is to be paid two dollars less than another type of hospital for identical ER services.
- B. A different rate is paid if a procedure includes a modifier indicating prenatal care.
- C. The rate for a procedure is different for an adult and a child.
- D. The rate was \$12 for the period 1/1/2007 – 11/130/2010 but changes to \$14 dollars for the period 12/1/2010 to 12/31/2299.

A physician is paid at 125% of the Max Fee amount for a procedure because of where she performed the procedure. What parameter causes this kind of change to a rate?

- A. Benefit Adjustment Factor
- B. Rate Type
- C. Pricing Indicator
- D. Procedure Modifier

Summary

In this topic, you learned about the following three parameters that affect how MITS pays a claim:

- Pricing Indicator
- Rate Type
- Benefit Adjustment Factor

In addition, you learned about the fields that appear on the **Rule Summary** panel.

Creating and Saving Reimbursement Rules

What

This task describes how to create reimbursement rules for claim pricing.

Who

This task is performed by a BPA Configuration Analyst with the appropriate MITS security role.

When

You perform this task when you receive a change order/directive that requires an update to policy rules in MITS.

Relevance

Within MITS, rules exist to define and manage the policies for processing and paying claims. A benefit is not covered unless it has a rule to cover it. You do not create rules for the purpose of denying claims, but rather for the purpose of paying them.

This task is important because the claims pricing function determines the pricing methodology used to calculate the amount paid for services rendered to eligible recipients.

Requirements

You must have an approved directive or policy change to perform this task.



A directive ties a rule back to the source of the policy. Without an approved directive, you cannot promote a rule.

Guidelines

- You can configure each rule to include, exclude, or bypass parameters when defining coverage for example: places of service, claim types, recipient plans, provider contracts, types of bill, diagnoses, provider types or specialties, modifiers, occurrence codes, and condition codes.
- All the reimbursement rules for a specific provider contract must exist on the same classification for a given benefit. The rules authoring panels will lock a recipient plan, provider contract, or reimbursement agreement to the first benefit classification where a rule has been authored.
- Anyone updating the Benefit Plans Administration (BPA) area should understand the Reference subsystem and also claims processing. Please review those files prior to adding or modifying any specific policy within BPA.
- Before you begin, verify that the CSR/directive is approved.
- The order in which you enter rules is critical in ensuring that the number of conflicting rules is limited during data entry. You should create group level rules first, and then any detail-level rules that are necessary. This means that you should create rules at the highest level of the hierarchy (tree) as possible.

How To

Follow these steps from the MITS home page to create reimbursement rules in the Reference subsystem:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Select Reimbursement Agreement from the Benefit Administration panel.						
4	Click Reimbursement Agreement under “ Select area to add or modify below ”.						
5	Search for and select the plan, contract, or agreement from the list of Search results.						
6	Find the level where you want to add a rule by following these steps: <table border="1" data-bbox="371 942 1373 1316"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> <ul style="list-style-type: none"> a. Select the desired type from the Type drop-down list. b. Select the desired code from the Code drop-down list. c. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> <ul style="list-style-type: none"> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	<ul style="list-style-type: none"> a. Select the desired type from the Type drop-down list. b. Select the desired code from the Code drop-down list. c. Click Find. 	Navigate the tree	<ul style="list-style-type: none"> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.
TO:	THEN:						
Search	<ul style="list-style-type: none"> a. Select the desired type from the Type drop-down list. b. Select the desired code from the Code drop-down list. c. Click Find. 						
Navigate the tree	<ul style="list-style-type: none"> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. 						
7	Select a directive from the Directive Version drop-down list. Note: If the directive for the new rule does not exist, you need to create the directive before completing this task.						
8	Right click the line item.						
9	Select the Add Rule option.						
10	Enter the desired information for the new rule. Note: Different types of codes display different options and criteria. Some options do not apply to every type of benefit code (i.e. procedure, diagnosis, etc.).						
11	Click Save to launch a three-step save process. Note: The first two steps interpret the rules and compare the new rule to existing						

Step	Action
	rules looking for overlaps and ambiguities. The third step validates the chosen directive and version.
12	<u>If the save is successful</u> , click OK to dismiss the confirmation window.
13	If the system finds a conflict: a. Click Cancel Save . b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again).

Success

You have successfully completed this task when confirmation displays "Save was successful."

The system performs a three-step save process that checks for conflicting rules and ambiguity. It will display warnings if it finds any conflicts or errors. These must be addressed and fixed before the update can be saved. At each step, the system allows you to back out of the save process and correct any problems.

Practice

Create a Reimbursement Rule using this information:

- **Provider Contract** - TRAIN
- **Procedures** (Training Ben Classif)
- Select a **Directive version** - CNV2009
- Drill down to: **All Procedures** -> **CPT** -> **Evaluation and Management**
- Use the table below to find your assigned benefit group and number:

Student	Group	Assigned Benefit Code
1	Acupuncture	97810
2	Acupuncture	97811
3	Acupuncture	97813
4	Acupuncture	97814
5	Hypnotherapy	90880
6	Biofeedback	90900
7	Biofeedback	90901
8	Biofeedback	90902
9	Biofeedback	90903
10	Biofeedback	90904
11	Biofeedback	90905
12	Biofeedback	90906
13-21	Biofeedback	90907-90915

- Add a direct rule.
- **Effective Date = 1/1/2010**
- **End Date = 12/31/2299** (You don't know if this rule will *ever* change)
- **Rate Type** = Def (Default)
- **Pricing Indicator** = Manual
- Save your new rule.

Summary

In this topic, you learned how to create a new reimbursement agreement rule.

Q&A

Rule Options

Overview

In this topic, you learn about the various rule options available in the rule edit panels.

Rules have different options for the various fields. By specifying the options, you configure and customize the coverage rules. Some options do not apply to all code types (i.e. procedure, diagnosis, NDC, etc.). When options do not apply, they are disabled (grayed out).

Field options include edits for the following:

- Yes/No editing
- Include/Exclude/No editing
- Include/Exclude/No with multiple fields
- Add Requirement (And/or editing)
- Simplify

Business Rules usually originate from state policy and the National Code List. They could also come from a provider inquiry. If a policy is not implemented according to its original intent, the state policy director can approve a course of action. This course of action includes one or more new business rules.

Yes/No Editing

Some rules have **Yes/No** options. **No** is the default for all Yes/No options. **No** requires no additional information be added. If you select **Yes**, other fields become available for editing, as in the example:

The screenshot displays the configuration interface for procedure 225. The left pane shows a tree view with 'Anesthesia' selected. The right pane shows configuration details for '225 for Procedures - All Procedures - CPT - Anesthesia'. The 'Modifier Editing' field is highlighted with a red box and set to 'Yes'. Below it, the 'Options' field is set to '[AA, AD, QK, QY]'. A text box explains that when 'Yes' is selected for 'Modifier Editing', the 'Options' field and others are opened for editing.

Modifier Editing is an example of Yes/No editing. When Yes is selected, the Options field and others are opened for editing.

In this example, the Modifier Editing field edit is set to Yes.

Include/Exclude/No Editing

The **Include/Exclude** coverage options default to **No**, which means additional information is not required for the rule. When you select the **Include** or **Exclude** option, the panel expands to show the available and assigned lists with line items that are available to apply to the coverage. Examples of this include Place of Service and Claim Type editing.



In this example, the Place of Service editing is set to **Include**. Any of the places of service shown in the **Places of Service Assigned** list would be allowed on the claim.

The buttons in the middle of the panel allow you to move selected codes from one list to the other, depending on the task.

To	Do this
Add a single item to the Assigned list:	Select the line item from the available list then click Add One (<) to move the selected item to the assigned list.
Add multiple items to the Assigned list:	Select a line item from the available list, hold down the Ctrl key to select the other line items, then click Add One (<) to move the selected items to the assigned list.
Select a range of items from the list to move	Select the first item from the list in the range and then hold down the Shift key and select the last item in the list. All items in the range are selected. Click Add One (<) to move the selected items to the assigned list.
Add all items from available list to assigned list	Click Add All (<<) to move the entire list from the available list to the assigned list.
Remove a single item from the Assigned list:	Select the line item and click Remove One (>) . The single line item moves back to the available list.

To	Do this
Remove multiple items from the Assigned list	Select a line item from the assigned list, hold down the Ctrl key to select the other line items, then click Add One (>) to move the selected items to the available list.
Remove all items from the Assigned field at one time:	Click Remove All (>>) . This moves all items back to the available list.

Reminder: Click the '-' symbol in the top left of each rule to minimize the panel. To expand the panel again, click the '+' panel for the full view of the rule.

Include/Exclude/No with Multiple Selection Fields Editing

The **Include/Exclude/No with Multiple Selections** option is similar to the **Include/Exclude/No Editing** option. The difference is when you select **Include** or **Exclude** during editing, the panel expands and displays multiple editing options, as well as the assigned list.

The table describes fields that use this option:

Provider Type/Specialty Assigned	Description
Billing Provider	Provider billing for the service.
Performing Provider	Provider performing the service.
Referring Provider	Provider referring a specialist.

Example Logic:

- If provider type and specialty are indicated for both billing and performing provider, then both the billing and performing conditions **must** be met.
- If multiple provider type specialties are indicated for a specific provider, **only one** of those conditions must be met.

Simplify

The **Simplify** option triggers MITS to review the selected/assigned values and reduce or combine the settings in order to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered. Note the location of the **Simplify** button.

The screenshot shows the 'Diagnosis' section of the MITS interface. It includes several dropdown menus for editing options: 'Primary Diagnosis Header Editing' (No), 'Diagnosis Header Secondary Editing' (No), 'Admitting Diagnosis Editing' (No), 'Emergency Diagnosis Editing' (No), and 'Diagnosis Detail Any Editing' (Yes). The 'Simplify' button is highlighted with a red box. Below these are 'Options' and 'Test Claim Value' fields, and a 'Diagnoses Assigned' list. The 'Available Diagnoses' section shows a range from 0010 to V8909.

Add Requirement

You use **Add Requirement** to add additional options on the same Options line. When you do this, you are adding an **AND** condition to the logic.

When you add an Options line by clicking **Add Option**, you are adding an **OR** condition to the logic.

When you modify the **Maximum** or **Minimum** fields, the **Add Requirement** button appears in the **Options** box. Click the **Add Requirement** button to begin adding a second range of (or individual) diagnosis code(s). MITS adds the item to the existing line or as a new option. This applies to both diagnosis and modifier editing.

The screenshot shows the 'Diagnosis Detail Any Editing' section with 'Yes' selected and the 'Simplify' button. In the 'Options' box, the 'Maximum' field is set to 4 and is highlighted with a red box. The 'Add Requirement' button is also highlighted with a red box. The 'Diagnoses Assigned' list now contains '502 - 700'. The 'Available Diagnoses' section shows three ranges: 0010 to 500, 501 to 501, and 7010 to V8909.

In the example, the diagnosis options were changed to a maximum of 4. Changing the value in the field causes the **Add Requirement** button to appear.

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

This rule option allows you to specify places of service allowed for a claim.

- A. Include/Exclude
- B. Multiple Choice
- C. Yes/No
- D. True/False

The **Add Requirement** button appears when you modify the values in the Maximum Diagnosis, Minimum Diagnosis or Modifier fields.

- A. True
- B. False

Click this button to simplify the requirements.

- A. Validate
- B. Check
- C. Cancel
- D. Simplify

Summary

In this topic, you learned about the rule options.

Updating/Modifying Rules Data

What

In this topic, you learn how to update rules in the Reference subsystem.

Who

A Configuration Analyst performs this task.

When

You may perform this task when you receive a policy change request/directive requiring an update to policy rules that are in the MITS system.

Relevance

Rule and Reference changes are associated with a directive, or policy change.

Requirements

To perform this task, you **must** have an approved directive or policy change.

A directive is assigned to the rule to tie it back to the source of the policy. Directives authorize the use of rules to enforce policy and subsequent versions of the directive provide history of the evolution of the directive.

How To

Follow these steps from the MITS home page to update or modify reimbursement rules in the Reference subsystem via the hierarchical tree structure:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Reimbursement Agreement .						
4	Select the provider contract with these instructions: <table border="1" data-bbox="371 718 1375 1102"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the provider contract in the search field. b. Click search. Note: The matching provider contract will display (or a list if you only typed the first letter). </td> </tr> <tr> <td>Navigate the search results list</td> <td> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).	Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.
TO:	THEN:						
Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).						
Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.						
5	To search for the level where you want to add a rule, follow these steps: <table border="1" data-bbox="371 1207 1375 1549"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> a. Click the + symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the + symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the + symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the + symbol until you reach the desired level.
TO:	THEN:						
Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .						
Navigate the tree	a. Click the + symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the + symbol until you reach the desired level.						
6	Click to expand rule criteria and review before making changes according to policy/directive.						
7	Select a directive from the Directive Version drop-down list.						
8	For a direct rule, click to expand the rule criteria. For an inherited rule, right click the rule and select Modify Rule (Excl/New) .						

Step	Action
9	Expand the desired area, and make the applicable changes in the rule.
10	Click Close . Note: If it was an inherited rule, both the excluded rule and new rule displays.
11	Click Save . This launches a three-step save process. The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen directive and version.
12	<u>If the save is successful</u> , click OK to dismiss the confirmation window.
13	If the system finds a conflict: a. Click Cancel Save b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again).

Note: You must correct all conflicts and errors. To back out of the save process, you may click **Cancel**. If you continue the save, the conflicting rules appear on the BPA Conflict Errors Report (in iTrace).

Success

You have successfully completed this task when the confirmation validation displays.

Practice

Practice modifying reimbursement rules using this information:

Practice #1

Modify the rule that you created:

- Provider Contract - TRAIN
- Click the rule that you just created in the Creating New Rules lesson.
- Change the End Date to 12/31/2010.
- Change the Pricing Indicator to MAX FEE.
- Change the Rate type to DEF.

Practice #2

Modify the rule that you inherited from your instructor using this information:

- Locate the inherited rule that appears under your assigned procedure code.
- Change End date to 12/31/2010.
- Pricing indicator: No Change
- Rate Type: No Change

Summary

In this topic you learned how to update an existing rule in MITS.

Q&A

Introduction to Rule Diagnosis Editing

Overview

In this lesson, you will learn about the Diagnosis Editing rule panel.

Types

Diagnosis codes may be found in several different places on the claim. Rules can be configured to perform diagnosis editing at the header or the detail level. They have different parameters and different numbers of allowable diagnoses. A few examples of this include:

- One provider contract may allow up to 8 diagnoses on the claim at the detail level.
- Another contract may allow up to 26 different diagnoses on the claim at the header level.

This table shows the type (location on claim) and what it evaluates:

Type of Diagnosis	Evaluates:
Primary Header	First diagnosis position in the header
Secondary Header	Second diagnosis in the header
Admitting	Admitting Diagnosis
Emergency	Emergency Diagnosis
Primary Detail	First diagnosis position in the detail
Secondary Detail	Second diagnosis in the detail
Any Header	Any diagnosis in the header
Other Header	Diagnosis in the header other than primary, secondary
Any Detail	Any diagnosis in the detail
Other Detail	Diagnoses other than primary or secondary in the detail

When you select **Yes** in the Diagnosis Editing drop-down list, the panel expands to show additional options that may be applied to the Coverage Rule. On some claims, the user has the option to add diagnoses in order to show when special conditions are required.

Diagnosis Editing Panel

You can perform diagnosis editing in recipient plans, provider contracts, reimbursement agreements, and global restrictions. Diagnosis editing options vary by benefit type; for example, Procedure to Diagnosis. The procedure requires one of the specified diagnoses to be a match.

Use the **Diagnosis Editing** panel to restrict benefits with the presence of another benefit on the claim. A typical example would be when a benefit is covered only when the primary diagnosis is in a specified group of diagnosis codes.

Business examples:

- When one of the selected diagnoses is required for the benefit procedure code to qualify for the rule.
- When a procedure that has one of the specified diagnoses requires a prior approval (PA), you can set up Diagnosis Editing with the PA indicator on.

Diagnosis ranges or individual codes can be put in the Assigned group to be checked during claim adjudication. The codes selected will appear in the Diagnoses Assigned box, and also in the area under Options with the dotted line around the box (called the current default option). As long as one of the Assigned diagnosis codes or combinations appears on the claim, it will qualify for covered services.

Different procedure diagnosis editing rules allow different numbers of diagnosis codes.

Examples include:

- Primary Header Diagnosis Editing allows 1 diagnosis code.
- Diagnosis Detail Other Editing allows 6 diagnosis codes.
- Diagnosis Header Any Editing allows 26.

Example

By using the options on the diagnosis fields, you are able to configure and customize the coverage rules. Some options are not applicable to every type of code (i.e. procedure, diagnosis, etc.). When the options are not applicable, the option is grayed out. For example, when in a rule edit panel for the revenue code benefit type, diagnosis header secondary editing is grayed out.

Diagnosis editing varies from program to program and benefit to benefit. This example shows three different options (they used Add Option to get three lines); with an AND on each line. Notice there is no Add Requirement in this panel. It does not display when all the options are being used. In this example, all 8 diagnoses are used in the options (7 in the first part, and 1 in the second part); so you can't add any more requirements.

1. This shows three alternative diagnosis edits. The first line represents this option: The claim can have up to seven diagnoses in the first group of ranges (0010-V219, V230-V8909), or it could have none of these. The 7 over 0 means maximum of 7 and minimum of 0.
2. The second portion of each option line with the AND specifies that it must have one in the second range (V220, V221, or V222).

1. Current option V220-V222 is selected and displays in the Diagnoses Assigned box.
2. The 1 over 1 means one of these 2 diagnoses must be on the claim with the others

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

This type of diagnosis evaluates any diagnosis code in the claim detail.

- A. Primary detail
- B. Secondary detail
- C. Any detail
- D. Other detail

The _____ section of the rule defines the diagnoses allowed on a claim that meets the rule criteria.

- A. Simplify
- B. Test Claim Value
- C. Available Diagnoses
- D. Options

Summary

In this topic, you learned about Diagnosis editing options.

Configuring Rule Diagnosis

What

In this topic you learn how to configure the Diagnosis edits on rules in the six benefit types in the Reference subsystem using the hierarchical tree structure. On some claims, you have the option to add diagnoses to indicate when special conditions are required.

Who

A configuration analyst performs the task.

When

You perform this task when you receive a change order/directive that requires diagnosis editing rules.

Requirements

You **must** have a directive/policy change with diagnosis requirements for a benefit code.

Guidelines

Diagnosis editing options vary by benefit type. The procedure requires that one of the specified diagnoses be a match.

How To

Follow these steps from the MITS Reference/Benefit Administration subsystem to configure rule diagnosis editing for a reimbursement rule:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Reimbursement Agreement .						
4	Select the provider contract with these instructions: <table border="1" data-bbox="371 751 1377 1136"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the provider contract in the search field. b. Click search. Note: The matching provider contract will display (or a list if you only typed the first letter). </td> </tr> <tr> <td>Navigate the search results list</td> <td> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).	Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.
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Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
6	Select a directive from the Directive Version drop-down box.						
7	Single click the rule to expand the rule window.						
8	Click the + to expand the Diagnosis section.						

Step	Action												
9	Click the Diagnosis Editing drop-down list and select Yes next to the desired selection. Note: Additional options may be applied to the Coverage Rule display.												
10	Configure the Diagnosis Editing by following these steps: <table border="1" data-bbox="371 489 1375 1776"> <thead> <tr> <th data-bbox="371 489 724 543">TO:</th> <th data-bbox="724 489 1375 543">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 543 724 720">Add/split a diagnosis range</td> <td data-bbox="724 543 1375 720"> a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Press the Enter key. d. Continue splitting the ranges as necessary. </td> </tr> <tr> <td data-bbox="371 720 724 926">Create a single diagnosis segment</td> <td data-bbox="724 720 1375 926"> a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Type the single diagnosis in both the From and To fields. d. Click outside the To field. </td> </tr> <tr> <td data-bbox="371 926 724 1255">Modify the current option where applicable</td> <td data-bbox="724 926 1375 1255"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter. e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. </td> </tr> <tr> <td data-bbox="371 1255 724 1677">Add diagnoses to the header Editing Rule</td> <td data-bbox="724 1255 1375 1677"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter. e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list. </td> </tr> <tr> <td data-bbox="371 1677 724 1776">Remove diagnoses from the Assigned list</td> <td data-bbox="724 1677 1375 1776"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. </td> </tr> </tbody> </table>	TO:	THEN:	Add/split a diagnosis range	a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Press the Enter key. d. Continue splitting the ranges as necessary.	Create a single diagnosis segment	a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Type the single diagnosis in both the From and To fields. d. Click outside the To field.	Modify the current option where applicable	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter . e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list.	Add diagnoses to the header Editing Rule	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter . e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list.	Remove diagnoses from the Assigned list	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option.
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	<table border="1"> <tr> <td data-bbox="375 279 727 390"></td> <td data-bbox="727 279 1377 390"> b. Click the single right (>) Assigned Diagnoses range to move the desired range to the Available Diagnoses list. </td> </tr> <tr> <td data-bbox="375 390 727 814">Add multiple diagnosis options</td> <td data-bbox="727 390 1377 814"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Type the total number of diagnoses allowed in the Maximum field, if required. c. Type the least amount of diagnoses allowed in the Minimum field, if required. d. Enter a valid diagnosis code that falls within the range of the original From and To fields. e. Press Enter. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list. </td> </tr> <tr> <td data-bbox="375 814 727 1203">Add a diagnosis requirement</td> <td data-bbox="727 814 1377 1203"> a. When the Maximum or Minimum fields are modified, the Add Requirement button appears in the Options box. b. Click Add Requirement. c. Click the Current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. d. Click the single right (>) arrow beside the desired Assigned Diagnoses range to move the desired range to the Available Diagnoses list. Note: The item is added to the existing line or as a new option. </td> </tr> </table>		b. Click the single right (>) Assigned Diagnoses range to move the desired range to the Available Diagnoses list.	Add multiple diagnosis options	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Type the total number of diagnoses allowed in the Maximum field, if required. c. Type the least amount of diagnoses allowed in the Minimum field, if required. d. Enter a valid diagnosis code that falls within the range of the original From and To fields. e. Press Enter. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list.	Add a diagnosis requirement	a. When the Maximum or Minimum fields are modified, the Add Requirement button appears in the Options box. b. Click Add Requirement . c. Click the Current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. d. Click the single right (>) arrow beside the desired Assigned Diagnoses range to move the desired range to the Available Diagnoses list. Note: The item is added to the existing line or as a new option.
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11	Click Simplify .						
12	Click Save .						
13	<u>If the save is successful</u> , click OK to dismiss the confirmation window.						
14	If the system finds a conflict: <ol style="list-style-type: none"> Click Cancel Save. Make the appropriate changes to the rule to resolve the conflict. Click Save (again). 						

Success

You have successfully completed this task when the confirmation window says that the update or new policy has been saved successfully.

Practice

Configure a diagnosis editing rule for a reimbursement agreement using this information:

- Provider Contract - TRAIN
- Use the same rule as previous lesson
- Open Diagnosis Detail Any Editing - Yes
- Split diagnosis range into 000 to 500
- New single diagnosis 501
- Remaining diagnosis range 502 to V8909
- Assign just the one individual diagnosis (501) to the Assigned box
- Save

Summary

In this topic, you learned how to configure a rule with diagnosis editing in MITS.

Q&A

Introduction to Rule Modifier Editing

Overview

In this lesson, you will learn about the Modifier Editing rule panel.

Modifier Editing Panel

For many claim benefit codes, you can configure rule modifiers to show if special conditions apply. To configure rule modifiers, use the **Modifier Editing** panel to:

- Add assigned modifier codes
- Modify the current option
- Disallow any modifier codes on a claim
- Add modifier requirements ("And")
- Add a modifier option ("Or")
- Delete a modifier option
- Add a new option
- Test system claim matches

Review the descriptions of the panel features.

Current Options lists modifiers QX and QZ. These are the only two options allowed for this procedure/rule.

Current Options also reflects the minimum and maximum values (1 and 1).

Options
[QX, QZ]

Modifiers Assigned
QX - CRNA SVC W/ MD MED DIRE
QZ - CRNA SVC W/O MED DIR BY

Available Modifiers
** - AUDIT DEFAULT MODIFIER
20 - MICROSURGERY
21 - PROLONGED E&M SERVICE
22 - UNUSUAL PROCEDURAL SE
23 - UNUSUAL ANESTHESIA
24 - UNRELATED E&M SAME MC

Test Claim Value: Inclusive
Maximum 1
Minimum 1

Panel Features	Description
Options (gray area)	Each claim can combine up to four modifiers for a benefit code. You may assign modifiers in any order in four positions. The system views all four positions or a combination of up to four modifiers, and then matches the modifiers based on these rules so the claim adjudicates. A dotted line in the Options area represents the currently selected option. Note: This panel prevents you from building multiple options if the maximum total across the multiple options is greater than four. You can also require that no modifiers show up on the claim.
Add Option button	When you want to add an "OR" option, use Add Option . MITS displays a new option below the first line.
Maximum and Minimum	For a procedure code to adjudicate: <ul style="list-style-type: none"> • Maximum must be set to the maximum number of modifiers allowed (1-4). These modifiers must come from the Available Modifiers pick list. • Minimum must be set to the minimum number of modifiers allowed (0-4).
Add Requirement button	When you modify the values in the Maximum or Minimum fields, Add Requirement (not shown) appears. Use Add Requirement when you want to add modifier requirements ("And") to the options. MITS adds the modifier to the existing line or as a new option.
Inclusive checkbox	A check in the Inclusive checkbox signals MITS to check any modifier added to the rule to ensure it is in the rule before it adjudicates. This checkbox is checked by default. If you deselect the checkbox, the rule states that a procedure is required and modifiers are not allowed.
Test Claim Values	Use to test the system and confirm that the rule and values are correct. You can type up to four values to cause a claim to match the selected modifiers OR type values to cause the test to return the "Does Not Match" message.
Matches?	After entering the test values, click Matches? to run a test. If the values meet the criteria, the test passes and the word "Matches" displays. Note: When you click Matches?, the values shift to the left to populate empty fields.
Simplify	Before you save, click Simplify . MITS reviews the options and reduces or combines the new option settings to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered.

Examples

The **Options** section on the rule editing panel defines the modifiers allowed for a specific claim. Each claim can combine a certain number of modifiers for a procedure code (the number of modifiers allowed may be different based on the benefit).

There can be multiple modifiers on a claim and the modifiers can arrive in any order. The system views all positions on the claim and then matches the modifier based on these rules so the claim adjudicates.

For a procedure code to be adjudicated:

- Maximum field must be set to the maximum number of modifiers codes allowed (1-4). These modifier codes must come from the **Available Modifiers** pick list.
- Minimum field must be set to the minimum number of modifiers allowed (0-4).
- Modifier(s) need to be selected from the **Available Modifiers** pick list and moved to the **Assigned Modifiers** list.

Screen shot - Rules modifier editing

Example 1: Current option modifier with additional options

Diagnosis Header Other Editing No

Provider Type/Specialty

Modifier Editing Yes Simplify

Options

[TH] ₁	and [24] ₀	and [GC, GE] ₀	and [25] ₀
[TH] ₁	and [24] ₀	and [SA, SB, UC] ₀	and [25] ₀
[TH] ₁	and [24] ₀	and [UD] ₀	and [25] ₀

Add Option

Test Claim Value Matches?

Inclusive

Maximum 1

Minimum 1

Delete Requirement

Modifiers Assigned

TH - OB TX/SRVCS PRENATL/POS

Available Modifiers

- *** - AUDIT DEFAULT MODIFIER
- 20 - MICROSURGERY
- 21 - PROLONGED E&M SERVICE
- 22 - UNUSUAL PROCEDURAL SE
- 23 - UNUSUAL ANESTHESIA
- 24 - UNRELATED E&M SAME MC

Current option line:
Possible modifier combinations:
TH
TH and 24
TH and GC
TH and GE
TH and 25
TH and 24 and GC
TH and 24 and GE
TH and 24 and GC and 25
TH and 24 and GE and 25

Occurrence Editing No

Condition Editing No

Example 2: No modifiers allowed

Provider Type/Specialty

Modifier Editing Yes

Options

[**]0 Add Requirement

Add Option

Test Claim Value: Matches?

Inclusive

Maximum 0

Minimum 0

Delete Requirement

Modifiers Assigned

** - AUDIT DEFAULT MODIFIER

Available Modifiers

- 20 - MICROSURGERY
- 21 - PROLONGED E&M SERVICE
- 22 - UNUSUAL PROCEDURAL SE
- 23 - UNUSUAL ANESTHESIA
- 24 - UNRELATED E&M SAME MC
- 25 - SIG SEP IDEN E&M SAME I

Occurrence Editing No

Note the following in this example:

- Maximum field is set to 0
- Modifiers Assigned is ****Audit Default Modifier**
- The **Inclusive** checkbox is checked.

Reimbursement Modifier Types

Modifiers serve different functions for reimbursement agreements than in provider contracts and recipient plans. This table describes some pricing modifiers and how they relate to the disposition of the claim.

Code	Title	Purpose
1	Pricing	These modifiers indicate a "look up" of the allowed amount for a procedure (examples are TC and 26). No entry is required in the BPA rules for a pricing modifier; it is done by table entry in the procedure panel.
2	Processing	Some modifiers pay a set dollar amount or percentage amount above the MAXFEE amount no matter what the circumstance is. A processing modifier changes the allowed amount by a specified percentage or dollar amount or changes the allowed units by a specified quantity.
3	Informational	These modifiers do not affect pricing at all, they just tell us a little bit more about the circumstances involved in how or why that procedure was billed.
4	Review	Indicates that the detail should be suspended for manual review
D	Denial	Will cause a detail to deny
M	Max Payment	Indicates the maximum payment allowed for a procedure billed with modifier of this type

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

A check in the _____ checkbox signals MITS to check any modifier added to the rule to ensure it is in the rule before it adjudicates.

- A. Maximum
- B. Minimum
- C. Inclusive
- D. Matches

Which of the following best describes the area called current default option in the **Modifier Editing** panel?

- A. Available Modifiers box
- B. Inclusive checkbox
- C. White Test Claim Value boxes
- D. Gray box with dotted line surrounding it and brackets inside

Summary

In this topic you learned about Modifier editing options.

Configuring Rule Modifiers

What

In this topic you learn how to configure rules with modifiers in the Reference subsystem via the hierarchical tree structure.

Who

A configuration analyst performs the task.

When

You may perform this task when you receive a change request (directive) to:

- Add assigned modifier codes
- Modify the current option
- Disallow any modifier codes on a claim
- Add modifier requirements ("And")
- Add a modifier option ("Or")
- Delete a modifier option
- Add a new option
- Test system claim matches

Relevance

You must properly configure rules with modifiers to ensure that MITS adjudicates the claim accurately.

Requirements

You must have an approved policy/directive before you perform this task.

How To

Follow these steps from the MITS Reference/Benefit Administration subsystem to configure a reimbursement rule modifier:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Reimbursement Agreement .						
4	Select the provider contract with these instructions: <table border="1" data-bbox="371 751 1377 1136"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the provider contract in the search field. b. Click search. Note: The matching provider contract will display (or a list if you only typed the first letter). </td> </tr> <tr> <td>Navigate the search results list</td> <td> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).	Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.
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Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
6	Select a directive from the Directive Version drop-down box.						
7	To modify an existing rule, click the rule to expand the rule window. To create a new rule, right click on the benefit level or code and select Add Rule.						
8	Select Yes in the Modifier Editing drop-down list.						

Step	Action												
9	Click the Options (gray area) to start the editing.												
10	<p>Configure Modifier Options by following these steps:</p> <table border="1" data-bbox="371 426 1373 1785"> <thead> <tr> <th data-bbox="375 426 691 478">TO:</th> <th data-bbox="691 426 1373 478">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 478 691 621">Add assigned modifier codes</td> <td data-bbox="691 478 1373 621"> a. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. b. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box. </td> </tr> <tr> <td data-bbox="375 621 691 982">Modify the current option</td> <td data-bbox="691 621 1373 982"> a. Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule. b. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field. c. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field. d. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. e. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list. </td> </tr> <tr> <td data-bbox="375 982 691 1188">Disallow any modifier codes on claim</td> <td data-bbox="691 982 1373 1188"> a. Ensure the Inclusive checkbox is checked. b. Select the first available modifier option ** - Audit Default Modifier. c. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0). </td> </tr> <tr> <td data-bbox="375 1188 691 1486">Add modifier requirements (AND condition)</td> <td data-bbox="691 1188 1373 1486"> a. Click Add Requirement. b. Click the area with the dotted line after and. c. Click the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned pick list. e. Click to select (or deselect) the Inclusive checkbox. f. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0). </td> </tr> <tr> <td data-bbox="375 1486 691 1785">Add modifier option (OR condition)</td> <td data-bbox="691 1486 1373 1785"> a. Click Add Option. b. Click the brackets inside the dotted line box. c. Click to select the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned list. e. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. f. Type the minimum number of Modifier codes allowed (1-4) in the Minimum field. </td> </tr> </tbody> </table>	TO:	THEN:	Add assigned modifier codes	a. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. b. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box.	Modify the current option	a. Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule. b. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field. c. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field. d. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. e. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list.	Disallow any modifier codes on claim	a. Ensure the Inclusive checkbox is checked. b. Select the first available modifier option ** - Audit Default Modifier . c. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0).	Add modifier requirements (AND condition)	a. Click Add Requirement . b. Click the area with the dotted line after and . c. Click the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned pick list. e. Click to select (or deselect) the Inclusive checkbox. f. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0).	Add modifier option (OR condition)	a. Click Add Option . b. Click the brackets inside the dotted line box. c. Click to select the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned list. e. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. f. Type the minimum number of Modifier codes allowed (1-4) in the Minimum field.
TO:	THEN:												
Add assigned modifier codes	a. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. b. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box.												
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Add modifier requirements (AND condition)	a. Click Add Requirement . b. Click the area with the dotted line after and . c. Click the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned pick list. e. Click to select (or deselect) the Inclusive checkbox. f. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0).												
Add modifier option (OR condition)	a. Click Add Option . b. Click the brackets inside the dotted line box. c. Click to select the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned list. e. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. f. Type the minimum number of Modifier codes allowed (1-4) in the Minimum field.												

Step	Action						
11	<p>Additional modifier options by following these steps:</p> <table border="1" data-bbox="375 359 1377 989"> <thead> <tr> <th data-bbox="375 359 727 415">TO:</th> <th data-bbox="727 359 1377 415">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 415 727 674">Simplify</td> <td data-bbox="727 415 1377 674"> Click Simplify. Note: The Simplify button reviews the options and reduces or combines the entered Option settings in order to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered. </td> </tr> <tr> <td data-bbox="375 674 727 989">Test Claim Matches</td> <td data-bbox="727 674 1377 989"> a. Type modifier value(s). b. Click Matches?. Note: These fields test the system to confirm that the entered modifier rules and values are correct. Once all of the options have been completed, enter up to four values that will either cause a claim to match the selected modifiers, or enter values that will cause the test to return the "Does not match" message. </td> </tr> </tbody> </table>	TO:	THEN:	Simplify	Click Simplify . Note: The Simplify button reviews the options and reduces or combines the entered Option settings in order to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered.	Test Claim Matches	a. Type modifier value(s). b. Click Matches? . Note: These fields test the system to confirm that the entered modifier rules and values are correct. Once all of the options have been completed, enter up to four values that will either cause a claim to match the selected modifiers, or enter values that will cause the test to return the "Does not match" message.
TO:	THEN:						
Simplify	Click Simplify . Note: The Simplify button reviews the options and reduces or combines the entered Option settings in order to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered.						
Test Claim Matches	a. Type modifier value(s). b. Click Matches? . Note: These fields test the system to confirm that the entered modifier rules and values are correct. Once all of the options have been completed, enter up to four values that will either cause a claim to match the selected modifiers, or enter values that will cause the test to return the "Does not match" message.						
12	Click Save .						
13	<p>If the system finds a conflict:</p> <ol style="list-style-type: none"> Click Cancel Save. Make the appropriate changes to the rule to resolve the conflict. Click Save (again). 						

Success

You have successfully completed this task when the validation confirmation displays.

Practice

Practice configuring a modifier editing rule, using the following information and the same reimbursement rule you used in last practice:

- Provider Contract - TRAIN
- Use the same procedure code you used in the last practice
- Choose 4 valid modifiers for the procedure code
- Assign the valid modifiers

Summary

In this topic, you learned how to configure a rule with modifier editing in MITS.

Q&A

Introduction to Removing a Rule

Overview

There are three different ways to remove existing rules:

- 1) Inactivate a rule.
- 2) Modify/Exclude an inherited rule.
- 3) Delete a rule.

Three ways

Since rules that apply at the top level of the tree structure affect all items in the associated subgroups, there might be a situation when you determine that a procedure code or codes that are currently part of an existing group level rule need to be modified or excluded from that particular rule. You need to distinguish between a direct rule and an inherited rule. To review the differences:

- The rule is a **direct** rule at the highest level that it applies.
- The rule is an **inherited** rule on codes that fall beneath the top level.

Action	Description
Modify a rule (excl/new)	This allows you to modify and edit the selected rule to include additional restrictions. Modify settings only apply to inherited rules.
Exclude a rule	This removes the inherited rule from a benefit in a subgroup/folder. Exclude settings only apply to inherited rules.
Inactivate a rule	This inactivates a rule from a group, subgroup, or specific benefit. This does not remove the rule from benefit or group. Upon inactivation, MITS sets the inactivate date for this benefit. Inactive rules may be activated again before the save process occurs. When you activate a rule again, MITS uses the same rule number. However, once saved, inactivated rules turn to the color pink and they cannot be re-activated. You can re-enter the rule manually, or request a programmer to re-activate the rule. Inactivate settings only apply to direct rules.

You have the option to **Delete** a rule only before the save process is completed. To delete a rule before saving it, right click the new rule and select **Delete Rule**.

Example

Rule 225 is a **direct** rule on the Anesthesia level; and the Forearm, Wrist, and Hand level procedures inherit the rule. The example shows the **Modify (Excl/New)** option used on procedure code 01829 to exclude rule 225. The new rule 81611 replaces the excluded rule.

The screenshot displays the 'Provider Type/Specialty' interface. At the top, it shows the 'Directive Version' as 'CNV2009 v1 Release SYSTEM IMP'. Below this, there are search fields for 'Type', 'Code', and 'Description', with a 'Find' button. The interface is set to 'Active Rules'. A tree view shows the following structure:

- Anesthesia
 - 225 DOS: 05/01/2001-12/31/2299 MOD: AA, AD, QK, QY 1:1 PDAT: 05/15/2009-12/31/2299
 - Burn Excisions Or Debridement
 - Forearm, Wrist, And Hand
 - 225 DOS: 05/01/2001-12/31/2299 MOD: AA, AD, QK, QY 1:1 PDAT: 05/15/2009-12/31/2299
 - 01810 ANESTH, LOWER ARM SURGERY
 - 01820 ANESTH, LOWER ARM PROCEDURE
 - 01829 ANESTH, DX WRIST ARTHROSCOPY**
 - Rule 225 excluded. Effective: 12/21/2009 (exclusion rule # = 81610)
 - 81611 DOS: 07/01/2003-12/31/2299 MOD: AA, AD, QK, QY 1:1 PDAT: 12/21/2009-12/31/2299
 - 01830 ANESTH, LOWER ARM SURGERY
 - 01832 ANESTH, WRIST REPLACEMENT
 - 01840 ANESTH, LWR ARM ARTERY SURG
 - 01842 ANESTH, LWR ARM EMBOLLECTOMY

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

The Modify (Exclude/New) option:

- A. Changes the inherited rule to an exclude status and adds a new rule in the same benefit/group level.
- B. Deletes the inherited rule from a benefit in a subgroup/folder.
- C. Inactivates a rule (but does not remove it) from a group, subgroup, or specific benefit.

Summary

In this topic you learned about removing rules.

Excluding/Inactivating Rules

What

This task describes how to remove rules in the Reference subsystem.

Who

A Configuration Analyst performs this task.

When

A Configuration Analyst performs this task when they receive a policy change request/directive that requires an update to policy rules in MITS.

Relevance

Perform this task when you determine that a procedure code(s) that is currently part of an existing group level rule needs to be modified or excluded from that particular rule.

Requirements

Perform this task when you have an approved **directive** or policy change.

You must also know whether this is a **direct** or an **inherited** rule.

How To

Follow these steps from the MITS home page to inactivate, exclude, or delete reimbursement rules:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Reimbursement Agreement .						
4	Select the provider contract with these instructions: <table border="1" data-bbox="371 751 1377 1136"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the provider contract in the search field. b. Click search. Note: The matching provider contract will display (or a list if you only typed the first letter). </td> </tr> <tr> <td>Navigate the search results list</td> <td> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).	Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.
TO:	THEN:						
Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).						
Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.						
5	To search for the level where you want to find a rule, follow these steps: <table border="1" data-bbox="371 1241 1377 1583"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.
TO:	THEN:						
Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .						
Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
6	Click to expand rule criteria and review before making changes according to policy/directive.						
7	Select a directive from the Directive Version drop-down list.						
8	Remove a rule based on the type of rule by following these steps:						

Step	Action										
	<table border="1"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Remove a direct rule</td> <td>Right click the rule and select Inactivate.</td> </tr> <tr> <td>Remove an inherited rule</td> <td>Right click the rule and select Exclude Rule.</td> </tr> <tr> <td>Remove an inherited rule, but add a new rule in its place</td> <td>Right click the rule and select Modify Rule (excl/new). The existing rule is now excluded; and a new rule edit panel displays. Now you can configure a new rule.</td> </tr> <tr> <td>Remove a rule before saving it</td> <td>Click Cancel.</td> </tr> </tbody> </table>	TO:	THEN:	Remove a direct rule	Right click the rule and select Inactivate .	Remove an inherited rule	Right click the rule and select Exclude Rule .	Remove an inherited rule, but add a new rule in its place	Right click the rule and select Modify Rule (excl/new) . The existing rule is now excluded; and a new rule edit panel displays. Now you can configure a new rule.	Remove a rule before saving it	Click Cancel .
TO:	THEN:										
Remove a direct rule	Right click the rule and select Inactivate .										
Remove an inherited rule	Right click the rule and select Exclude Rule .										
Remove an inherited rule, but add a new rule in its place	Right click the rule and select Modify Rule (excl/new) . The existing rule is now excluded; and a new rule edit panel displays. Now you can configure a new rule.										
Remove a rule before saving it	Click Cancel .										
9	<p>Click Save.</p> <p>This launches a three-step process. The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen Directive and Version.</p>										
10	<u>If the save is successful</u> , click OK to dismiss the confirmation window.										
11	<p>If the system finds a conflict:</p> <ol style="list-style-type: none"> Click Cancel Save Make the appropriate changes to the rule to resolve the conflict. Click Save (again). 										

Note: The delete option is only found on a new rule.

Success

You have successfully completed this task when the validation confirmation displays.

Practice

Practice inactivating a reimbursement rule using this information:

- Reference>Benefit Administration>Reimbursement Agreements
- Use the rule that you created.
- Inactivate the rule you created at the benefit code level.
- When you are done, save and then view rule summary to verify it is inactivated.

Summary

In this topic, you learned how to exclude and inactivate rules.

Q&A

Introduction to Conflict Report Errors

Overview

In this lesson, you will learn about the Conflict Error Reports in iTrace.

Conflict Error Report

You use the Conflict Error Report to help resolve errors and conflicts. The Conflict Error Report lists all unresolved conflicts as a result of the rule creation process outside the three-step save process. If there are any conflicts, the report identifies the specific location within that BPA area by its System Assigned Key (SAK) number, the rule number, the benefit group or benefit code, and the reason for the conflict so that the BPA analyst can trace back to the source of the conflict for corrective action.

Many of the records on the report are not errors or conflicts, but just there to show that rules may exist for that benefit. It is relatively easy to recognize the conflict records, as shown in the sample report below:

```

Decision [AD] with 2 rules.
SAK_FUB_HLTH 42 with 1 rules
SAK_FUB_HLTH 40 with 1 rules
Decision [AG] with 0 rules.
Decision [AI] with 0 rules.
Decision [ANI] with 0 rules.
Decision [AW] with 328 Rules.
SAK_FUB_HLTH 42 with 1 rules
SAK_FUB_HLTH 40 with 327 rules
Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
Rule # 94086 for benefit [50163] doesn't have a container.
Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
Rule # 94087 for benefit [50163] doesn't have a container.
Overlaps and/or orphaned exclusions exist for Procedure 00869. Has 4 rules (2 not inherited)
Rule #93951 is an orphaned exception for rule 80269
--Date Range - 01/01/2002-06/30/2003
--OVERLAPPED RULE -- 93952 has the same output variable(s) but overlaps 93888
First rule eclipsed by second.
93952 DOS: 01/01/2002-06/30/2003 CHP: 40 PROC: 00869--ANESTH, VASECTOMY PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 2...
93888 DOS: 05/01/2001-12/31/2299 BGRP: 320003--Anesthesia CHP: 40 PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 20/000,...
Overlaps and/or orphaned exclusions exist for Procedure 20930. Has 2 rules (2 not inherited)
Rule #93955 is an orphaned exception for rule 93886
Overlaps and/or orphaned exclusions exist for Procedure 20936. Has 2 rules (2 not inherited)
Rule #93957 is an orphaned exception for rule 93886
Overlaps and/or orphaned exclusions exist for Procedure 36489. Has 3 rules (3 not inherited)
--Date Range - 01/01/2000-12/31/2299
--OVERLAPPED RULE -- 94002 has the same output variable(s) but overlaps 94003

```

No Errors or Conflicts

Conflicts - Overlapping Dates

The Conflict Report shows you what benefit group or benefit code a rule is based on, and using this information, you must know what panel to go to in MITS to correct the error. The **1st letter/Description** column indicates the submenu you use under Reference>Benefit Administration. The **2nd letter/Description** columns indicate the benefit group to search for codes. These are some key terms to aid in understanding the conflict report.

1st letter	Description	2nd letter	Description
A	Assignment Plan	D	Diagnosis
B	Benefit Plan	I	ICD-9 Procedure
C	Copay	G	DRG
G	Global Restrictions	N	Drug/NDC
O	Other Insurance	P	Procedure
P	Provider Contract	R	Revenue Code
R	Reimbursement Agreement		

Examples:

- AI = a rule decision was made on the Assignment Plan panel under the ICD-9 Procedure Benefit Type
- RP = a rule decision was made on the Reimbursement Agreement panel under the Procedure Benefit Type

Benefit Plan Spreadsheet

You use the Conflict Error Report to help resolve errors and conflicts. The Conflict Error Report lists all unresolved conflicts as a result of the rule creation process outside the three-step save process. If there are any conflicts, the report identifies the specific location within that BPA area by its System Assigned Key (SAK) number, the rule number, the benefit group or benefit code, and the reason for the conflict so that the BPA analyst can trace back to the source of the conflict for corrective action.

Many of the records on the report are not errors or conflicts, but just there to show that rules may exist for that benefit. It is relatively easy to recognize the conflict records, as shown in the sample report below:

```

Decision [AD] with 2 rules.
SAK_PUB_HLTH 42 with 1 rules
SAK_PUB_HLTH 40 with 1 rules
Decision [AG] with 0 rules.
Decision [AI] with 0 rules.
Decision [AN] with 0 rules.
Decision [AV] with 527 rules.
SAK_PUB_HLTH 42 with 1 rules
SAK_PUB_HLTH 40 with 527 rules
--
Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
Rule # 94086 for benefit [50163] doesn't have a container.
Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
Rule # 94087 for benefit [50163] doesn't have a container.
Overlaps and/or orphaned exclusions exist for Procedure 00869. Has 4 rules (2 not inherited)
Rule #93951 is an orphaned exception for rule 80269
--Date Range - 01/01/2002-06/30/2003
--OVERLAPPED RULE -- 93952 has the same output variable(s) but overlaps 93888
First rule eclipsed by second.
93952 DOS: 01/01/2002-06/30/2003 CHP: 40 PROC: 00869--ANESTH, VASECTOMY PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 2...
93888 DOS: 05/01/2001-12/31/2299 BGRP: 320003--Anesthesia CHP: 40 PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 20/000,...
Overlaps and/or orphaned exclusions exist for Procedure 20930. Has 2 rules (2 not inherited)
Rule #93955 is an orphaned exception for rule 93886
Overlaps and/or orphaned exclusions exist for Procedure 20936. Has 2 rules (2 not inherited)
Rule #93957 is an orphaned exception for rule 93886
Overlaps and/or orphaned exclusions exist for Procedure 36489. Has 3 rules (3 not inherited)
--Date Range - 01/01/2000-12/31/2299
--OVERLAPPED RULE -- 94002 has the same output variable(s) but overlaps 94003
    
```

No Errors or Conflicts

Conflicts - Overlapping Dates

The Benefit Plan Spreadsheet indicates what group is represented on the Conflict Error Report. Review this report to identify what program has conflicts.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P										
1	SAK_PUB	SAK_FIN	CDE_PGM	DSC_PGM	DSC_PGM	CDE_TYP	IND	RECH	IND	MAJ	IND	CT	E	IND	COP	IND	DUAL	IND	TPL	/NUM	HIEF	NUM	HIEF	DTE	EFFE
2	0	1	ALL	All	Benefit	All	Benefit	BNFT	N													1		0	19900101
3	1	1	MCAID	Medicaid	Full	medic	BNFT	N															0	19900101	
4	2	1	IO14	Individual	Individual	CBNFT	N																0	19900101	
5	3	1	DMA	Disability	Disability	BNFT	N																0	19900101	
6	4	1	DISIV	Disability	Disability	BNFT	N																0	19900701	
7	5	1	CHOIC	Choices	Choices	BNFT	N																0	20011101	
8	9	1	ASL	Assisted L	Ohio Dept	BNFT	N																0	20060701	
9	10	1	ALIEN	Emergency	Temporary	BNFT	N		N		N		N		N							10	0	19900101	
10	11	1	ALCRX	ODADAS	ODADAS	BNFT	N		N		N		N		N								11	0	19900101
11	12	1	AIDS	Aids	Waiv	Aids	Waiv	BNFT	N		N		N		N								12	0	19880101
12	13	1	VNT50	Model 50	Model 50	BNFT	N		N		N		N		N								13	0	19860917
13	14	1	VENT	Ventilator	Ventilator	BNFT	N		N		N		N		N								14	0	19891215
14	15	1	TRCO	Transitions	Transitions	BNFT	N		N		N		N		N								15	0	20060701
15	16	1	TMRDD	Transitions	Transitions	BNFT	N		N		N		N		N								16	0	20020101
16	17	1	SLMB	SLMB	Special	Lo	BNFT	N		N		N		N		N							17	0	19900101
17	18	1	RES14	Residentia	Residentia	BNFT	N		N		N		N		N								18	0	19900101
18	19	1	RES	Residentia	Residentia	BNFT	N		N		N		N		N								19	0	19900101
19	20	1	REF	Refugee	Refugee	BNFT	N		N		N		N		N								20	0	19900101
20	21	1	QWDI	Qualified V	Qualified V	BNFT	N		N		N		N		N								21	0	19900101
21	22	1	QMB	Qualified N	Qualified N	BNFT	N		N		N		N		N								22	0	19900101
22	23	1	QI 1	QI 1/QI 2	Special	Lo	BNFT	N		N		N		N		N							23	0	19900101
23	24	1	PASSP	Passport V	Preadmiss	BNFT	N		N		N		N		N								24	0	19900701
24	25	1	PAS14	Passport V	Passport V	BNFT	N		N		N		N		N								25	0	19900101
25	26	1	PACE	Pace	Pace	BNFT	N		N		N		N		N								26	0	19960930
26	27	1	OOHC	Old Ohio F	Old Ohio F	BNFT	N		N		N		N		N								27	0	19980701
27	28	1	OMH	Ohio Ment	Ohio Ment	BNFT	N		N		N		N		N								28	0	19900101
28	29	1	OHC	Ohio Hom	Ohio Hom	BNFT	N		N		N		N		N								29	0	20060701
29	30	1	OBRA	Obra-Waiv	Obra-Waiv	BNFT	N		N		N		N		N								30	0	19900101
30	31	1	MSP	Medicaid	Medicaid	BNFT	N		N		N		N		N								31	0	20050701
31	32	1	MRLV1	MR Level 1	MR Level 2	BNFT	N		N		N		N		N								32	0	20021201
32	33	1	MRIO	MR IO	MR IO	BNFT	N		N		N		N		N								33	0	19910301
33	34	1	MOD50	Model 50 /	Model 50 /	BNFT	N		N		N		N		N								34	0	19831001
34	35	1	MCABD	HMO, ABE	HMO, ABE	ASGN	N		N		N		N		N								0	1	19900101
35	36	1	KTRNA	Katrina W;	Katrina W;	ASGN	N		N		N		N		N								0	2	20050901
36	37	1	HOSPC	Hospice	Hospice	ASGN	N		N		N		N		N								0	3	19900101
37	38	1	CDPHY	County Dn	County Dn	ASGN	N		N		N		N		N								0	4	19900101
38	39	1	CDPHR	County Dn	County Dn	ASGN	N		N		N		N		N								0	5	19900101
39	40	1	PACTP	PACT Phy	PACT Phy	ASGN	N		N		N		N		N								0	6	19900101
40	41	1	PACTD	PACT Pha	PACT Pha	ASGN	N		N		N		N		N								0	7	19900101
41	42	1	PACEA	PACE	PACE	ASGN	N		N		N		N		N								0	8	19900101
42	43	1	MCFEC	HMO	CFHMO	CFHMO	ASGN	N		N		N		N		N							0	9	19900101

The Benefit Plan Spreadsheet indicates what group is represented on the Conflict Error Report. Review this report to identify what program has conflicts.

Ambiguous Error – When two or more rules with different rule variables are active for the same benefit group or code the Rules Engine cannot determine which rule to choose. The BPA analyst has to decide which rule is the correct rule for the benefit group or code and to inactivate the rule(s) that should not remain active.



Overlapping Error – When two or more rules with the same rule variables are active for the same benefit group or code the Rules Engine cannot determine which rule to choose. The BPA analyst has to decide which rule is the correct rule for the benefit group or code and to inactivate the rule(s) that should not remain active.

SAK – System Assigned Key – a number or code that represents an entity within a database.

Contract Spreadsheet

You scroll down the Conflict Report and find contract errors, as shown here.

```

Decision [PP] with 21553 rules. 1
SAK_PROV_PGM 37 with 36 rules
----Classification sak is 112 -----
SAK_PROV_PGM 62 with 5 rules
----Classification sak is 106 -----
SAK_PROV_PGM 61 with 9 rules
----Classification sak is 136 -----
Rule Sak# 77 has benefit = T2029 - SPECIAL MED EQUIP, NOSWAIVER which isn't in this classification
Rule Sak# 75 has benefit = S5101 - ADULT DAY CARE PER HALF DAY which isn't in this classification
Rule Sak# 79 has benefit = S5161 - EMER RSPNS SYS SERV PERMONTH which isn't in this classification
Rule Sak# 78 has benefit = S5160 - EMER RESPONSE SYS INSTAL&TST which isn't in this classification
Rule Sak# 81 has benefit = S5170 - HOMEDELIVERED PREPARED MEAL which isn't in this classification
Rule Sak# 76 has benefit = S5102 - ADULT DAY CARE PER DIEM which isn't in this classification
Rule Sak# 80 has benefit = S5165 - HOME MODIFICATIONS PER SERV which isn't in this classification
Rule Sak# 73 has benefit = H0045 - RESPITE NOT-IN-HOME PER DIEM which isn't in this classification
Rule Sak# 74 has benefit = S0215 - NONEMERG TRANSP MILEAGE which isn't in this classification
SAK_PROV_PGM 28 with 72 rules
----Classification sak is 134 -----
SAK_PROV_PGM 25 with 8 rules
----Classification sak is 136 -----
SAK_PROV_PGM 55 with 109 rules
----Classification sak is 141 -----
SAK_PROV_PGM 50 with 531 rules. 2
----Classification sak is 144 -----
Rule Sak# 82211 has BGRP=314547, but this group does not exist. 3
Rule Sak# 82212 has BGRP=314547, but this group does not exist.
Rule Sak# 82205 has BGRP=314545, but this group does not exist.
Rule Sak# 82206 has BGRP=314545, but this group does not exist.
Rule Sak# 82197 has BGRP=314542, but this group does not exist.
Rule Sak# 82198 has BGRP=314542, but this group does not exist.
Rule Sak# 82217 has BGRP=314548, but this group does not exist.
Rule Sak# 82218 has BGRP=314548, but this group does not exist.

```

The Contract Spreadsheet lists the contracts in MITS. You review this spreadsheet to find which contract is identified on the Conflict Error Report.

	F	G	H	I	J	K
1	DSC_PROV_PGM_LONG	IND_CT_EDITING	DTE_EFFECTIVE	DTE_END	DTE_INACTIVE	
40	PACE Contract		19000101	22991231	31-DEC-99	
41	ODA PASSPORT Waiver Contract		19000101	22991231	31-DEC-99	
42	Private Duty Nurse (PDN) Contract		19000101	22991231	31-DEC-99	
43	Pharmacy Contract (No Services)		19000101	22991231	31-DEC-99	
44	Physician Contract		19000101	22991231	31-DEC-99	
45	Podiatry Contract		19000101	22991231	31-DEC-99	
46	Psychology Contract		19000101	22991231	31-DEC-99	
47	Portable X-Ray Supplier Contract		19000101	22991231	31-DEC-99	
48	Rural Health Center (RHC) Contract		19000101	22991231	31-DEC-99	
49	State Plan Home Health Contract		19000101	22991231	31-DEC-99	
50	Therapy Contract		19000101	22991231	31-DEC-99	
51	Veteran Home Contract (No Services)		19000101	22991231	31-DEC-99	
52	Vision Contract		19000101	22991231	31-DEC-99	
53	Wheelchair Van Contract		19000101	22991231	31-DEC-99	
54	Waiver Fiscal Intermediary		19000101	22991231	31-DEC-99	
55	ODJFS Waiver Attendant Care Services Contract		20090701	22991231	31-DEC-99	
56	ODJFS Waiver (non-core) Service Contract		20060701	22991231	31-DEC-99	
57	ODJFS Waiver Nursing Services Contract		20060701	22991231	31-DEC-99	
58	ODJFS Waiver Personal Care Service Contract		20060701	22991231	31-DEC-99	
59						

Use the Contract Spreadsheet from iTrace to identify the contract from the conflict report.

Reports

Listed below are the most commonly-used reports for (course subject):

ID, if applicable	Report Name	Frequency	Report Description
	Conflict Error Report	Daily	Displays rule updates and conflicts.
	Benefit Plan Spreadsheet	Daily	Displays the benefit plans and codes
	Contract spreadsheet	Daily	Displays the SAK codes to all the contracts.

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

You find the Conflict Error Report, the Benefit Plan Spreadsheet, and the Contract Spreadsheet in iTrace.

- A. True
- B. False

All items listed in the Conflict Error Report are errors that must be fixed ASAP.

- A. True
- B. False

The name of the report that you use to identify the recipient plan with conflicts on the conflict report is the _____.

- A. Contract spreadsheet
- B. Plan Spreadsheet
- C. Excel spreadsheet

Summary

In this topic you learned about using the conflict error report, the benefit plan spreadsheet, and the contract spreadsheet to resolve rule conflict errors.

Correcting Conflict Report Errors

What

In this topic, you learn how to access the Conflict Report, Benefit Plan Spreadsheet, and Contract Spreadsheet in iTrace so that you can resolve rule conflicts or errors in MITS.

Who

A BPA Configuration analyst performs this task.

When

Perform this task as needed.

Relevance

When rules are saved in the Reference subsystem manually, MITS performs a three-step save process. The three-step save process includes checks for:

- State conflicts
- Simplification
- Directive validation

However, when rules are loaded by a batch job, the Conflict Error Report identifies any rule errors that did not go through the three-step save process. This process should keep conflict errors to a minimum. You need to identify and analyze conflicts occasionally that do not engage the three-step save process.

Requirements

To correct the Conflict Report errors, you need the following items:

- Conflict Report/Conflict Results log from iTrace to identify errors and conflicts
- Benefit Plan Spreadsheet from iTrace to identify represented program codes
- Contract Spreadsheet from iTrace to identify represented contracts
- MITS (BPA rule panel in conflict) to correct the error

How To

You will use reports from iTrace; and the errors will be corrected in MITS.

Step	Action						
1	<p>Access the reports by following these steps:</p> <ol style="list-style-type: none"> From the iTrace home page, select Tech Design>Reference Data Maintenance. Scroll down to the BPA Reports heading and select Conflict Report. Select a conflict log report from the list (recommend selecting the most recent conflict report). If desired, print the report. Click Back on the iTrace browser window to return to the previous screen. Under Benefit Plan Administration heading, select Plan Spreadsheet. Note: The Benefit Plan Table Load opens as a separate spreadsheet, which you can view, print, or download. Under Benefit Plan Administration heading, select Contract Spreadsheet. Close the documents, when finished. 						
2	From the MITS home page, navigate to Reference>Benefit Administration .						
3	Click the appropriate menu (i.e., Provider Contract, Recipient Plan, Reimbursement Agreement, Global Restrictions).						
4	<p>Select the appropriate contract/plan/agreement/restriction using these instructions:</p> <table border="1" data-bbox="371 1171 1377 1556"> <thead> <tr> <th data-bbox="371 1171 656 1226">TO:</th> <th data-bbox="656 1171 1377 1226">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 1226 656 1413">Search</td> <td data-bbox="656 1226 1377 1413"> <ol style="list-style-type: none"> Type the contract/plan/agreement in the search field. Click search. Note: The matching contract/plan/agreement/restriction will display (or a list if you only typed the first letter). </td> </tr> <tr> <td data-bbox="371 1413 656 1556">Navigate the search results list</td> <td data-bbox="656 1413 1377 1556"> <ol style="list-style-type: none"> Navigate the list by clicking the page numbers and/or the Next > page icon. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	<ol style="list-style-type: none"> Type the contract/plan/agreement in the search field. Click search. Note: The matching contract/plan/agreement/restriction will display (or a list if you only typed the first letter).	Navigate the search results list	<ol style="list-style-type: none"> Navigate the list by clicking the page numbers and/or the Next > page icon. Click the provider contract row from the Search Results list.
TO:	THEN:						
Search	<ol style="list-style-type: none"> Type the contract/plan/agreement in the search field. Click search. Note: The matching contract/plan/agreement/restriction will display (or a list if you only typed the first letter).						
Navigate the search results list	<ol style="list-style-type: none"> Navigate the list by clicking the page numbers and/or the Next > page icon. Click the provider contract row from the Search Results list. 						

Step	Action												
5	<p>To search for the level where you want to find a rule, follow these steps:</p> <table border="1" data-bbox="375 363 1377 699"> <thead> <tr> <th data-bbox="375 363 727 415">TO:</th> <th data-bbox="727 363 1377 415">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 415 727 562">Search</td> <td data-bbox="727 415 1377 562"> a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find. </td> </tr> <tr> <td data-bbox="375 562 727 699">Navigate the tree</td> <td data-bbox="727 562 1377 699"> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
TO:	THEN:												
Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .												
Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.												
6	<p>Left click the benefit code above where the rule was placed to view the rule summary. Note: Review the summary before making changes according to policy/directive.</p>												
7	<p>Select a directive from the Directive Version drop-down list.</p>												
8	<p>Correct the errors by following these steps:</p> <table border="1" data-bbox="375 1014 1377 1633"> <thead> <tr> <th data-bbox="375 1014 727 1066">IF:</th> <th data-bbox="727 1014 1377 1066">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1066 727 1182">A direct rule is incorrect and needs to be modified</td> <td data-bbox="727 1066 1377 1182"> a. Left click the direct rule. b. Modify the rule edit panel as appropriate </td> </tr> <tr> <td data-bbox="375 1182 727 1297">An inherited rule is incorrect only and needs to be modified</td> <td data-bbox="727 1182 1377 1297"> a. Right click the rule. b. Select Modify Rule (excl/new). c. Edit the new rule panel. </td> </tr> <tr> <td data-bbox="375 1297 727 1413">A direct rule is incorrect and needs to be removed</td> <td data-bbox="727 1297 1377 1413"> a. Right click the rule. b. Select Inactivate. </td> </tr> <tr> <td data-bbox="375 1413 727 1539">An inherited rule is incorrect only and needs to be removed</td> <td data-bbox="727 1413 1377 1539"> a. Right click the rule. b. Select Exclude. </td> </tr> <tr> <td data-bbox="375 1539 727 1633">A new rule is required</td> <td data-bbox="727 1539 1377 1633"> a. Right click the benefit level b. Select Add rule. </td> </tr> </tbody> </table>	IF:	THEN:	A direct rule is incorrect and needs to be modified	a. Left click the direct rule. b. Modify the rule edit panel as appropriate	An inherited rule is incorrect only and needs to be modified	a. Right click the rule. b. Select Modify Rule (excl/new) . c. Edit the new rule panel.	A direct rule is incorrect and needs to be removed	a. Right click the rule. b. Select Inactivate .	An inherited rule is incorrect only and needs to be removed	a. Right click the rule. b. Select Exclude .	A new rule is required	a. Right click the benefit level b. Select Add rule .
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A direct rule is incorrect and needs to be removed	a. Right click the rule. b. Select Inactivate .												
An inherited rule is incorrect only and needs to be removed	a. Right click the rule. b. Select Exclude .												
A new rule is required	a. Right click the benefit level b. Select Add rule .												
9	<p>Click Save. This launches a three-step process. The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen Directive and Version.</p>												

Step	Action
10	If the save is successful, click OK to dismiss the confirmation window.
11	If the system finds a conflict: a. Click Cancel Save b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again).

Success

You have successfully completed this task when the validation confirmation displays.

Summary

In this topic you learned how to use the conflict report in iTrace to correct conflict report errors in MITS.

Q&A

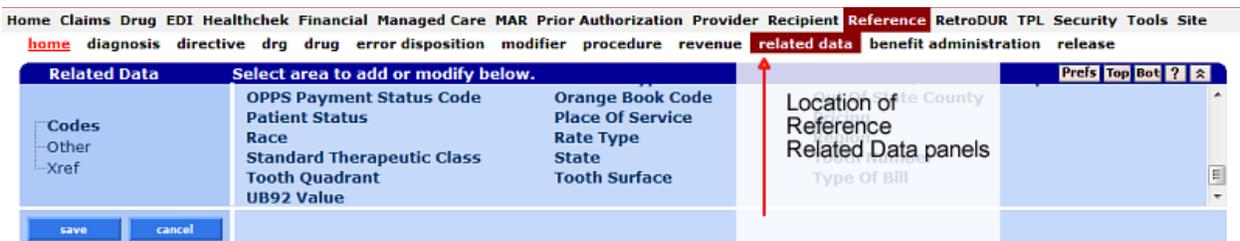
Related Data Maintenance

Overview

In this lesson, you will learn about the **Reference Related Data** panels that you can use to add new options to the following rule parameter drop-down lists:

- Pricing Indicator
- Rate Type
- Benefit Adjustment Factor

The image illustrates the location of the **Reference Related Data** panels.



Rate Type

The rate type parameter allows the pricing table to hold different rates, for the same benefit, at the same time.

The image illustrates the panel that you use to add a new rate type to MITS.



Although rare, some new rate types **may** require additional configuration or programming outside of MITS, after you complete the setup task using this panel. If you are unsure of whether your new rate type requires additional programming outside of MITS, discuss it with a technical leader.

Pricing Indicator

The MITS pricing indicator function specifies the payment methodology to apply when determining the payment to a provider for a procedure.

The panel illustrates the panel that you use to create a new pricing indicator.

The screenshot shows the 'Related Data' and 'Pricing' sections of the MITS interface. The 'Related Data' section has a 'Codes' dropdown menu with 'Pricing' selected. The 'Pricing' section contains a table of existing pricing indicators and a form to add a new one.

Related Data Section:

- Codes: Pricing
- Other: (empty)
- Xref: (empty)

Pricing Table:

Pricing	Description	HCPCS Procedure Indicator
ANESTH	Anesthesia	YES
ASC	Ambulatory Surgery Center	YES
BILLED	Pay as Billed	YES
DMEPA	DME Repair - over \$100	YES
DRG	Diagnosis Related Group	NO
DRGPDM	IP DRG trans/par eligible	NO
DRG_OL	Special DRG Outlier	NO
ENPRIC	Encounters - price at \$0	YES
FLTTEE	Revenue Code Flat Fee	NO
HHPDN	Home Health - PDN	YES

Form Section:

Pricing:

Description:

HCPCS Procedure Indicator:

Buttons: delete, add

Callouts:

- Pricing is located in the Codes section of related data.
- Click to add a record
- Complete the required information
- Save your new pricing indicator



Pricing indicators **always** require additional configuration or programming outside of MITS, after you complete the setup task using this panel. Discuss the addition of new pricing indicators with a technical leader to ensure that the new pricing indicator functions correctly.

Benefit Adjustment Factor

The Benefit Adjustment Factor (BAF) function provides the ability to alter an existing allowed amount by a set percentage, a series of percentages, or a dollar amount to increase or reduce the allowed amount by the percentage or dollar amount assigned.

This type of adjustment works in conjunction with pricing methodologies to apply a percentage to the allowed amount. This enhancement allows the user to alter a rate utilizing different criteria without having to create new rates.

The image illustrates the panel that you use to create a new rate type.

Related Data Select area to add or modify below. Prefs Top Bot ? ↕

Adjustment Reason Group Type
Benefit Adjustment Factor
 Diagnosis Group Type
 Drug Parm Rate
 Extreme Cost
 Outlier

Anesthesia Conversion Factor
 Business Area
 Dispensing Fee
 EOB
 Federal Medical Asst Percent
 HCPCS Procedure Grp Typ

ASC Pricing
 Conversion
 DRG Group Type
 Estimated Acquisition Cost Pct
 Geographic Practice Cost Idx
 HIC Group Type

Codes
 -Other
 -Xref

save

Benefit Adjustment Factor Top Nav ? A ↕ X

BAF ID	BAF Name	Description
1028	\$15	Place of Service differential +\$15
1030	\$25	Place of Service differential +\$25 (D9220 - in clinic, office, or NF)
1032	\$50	Place of Service differential +\$50
1034	140%	Special provisions for reimbursement for physician groups acting as ou
1036	85%	APN modifiers SA, SB, and UC in a hospital place of service - 85% of t
1042	50%	Multiple BAFs - Non-physicians billing psychiatric codes with modifier
1046	25%	Transportation modifier U2 pays 25% of base rate
1048	48%	Transportation modifier U3 pays 48% of base rate for mileage (services 442
1050	28%	Transportation modifier U3 pays 28% of base rate for services (services 442
1052	108%	DME modifier U1 pays 108% of base rate (oxygen concentrator in p

1 2 Next >

-Benefit Adjustment Factor Type- Type changes below.

BAF Name

Description

delete add

-Benefit Adjustment Factor Rate- The data below is for the row selected above.

*** No rows found ***

Select row above to update -or- click Add button below.

Rate Effective Date

Percent End Date

Calculate Code Inactive Date

delete add

4 Save your new adjustment factor

1 Benefit Adjustment Factor is located in the Other section of related data.

2 Click to add a record

3 Complete the required information

Check Your Understanding

This activity contains questions to assess your understanding of key concepts in this topic. Review the topic if your score is below your standards.

The Benefit Adjustment Factor link appears on the **Codes** panel with the Pricing Indicator and Rate Type links.

- A. True
- B. False

Which one of the following reimbursement agreement parameters **always** requires system programming after you add the new parameter in MITS?

- A. Benefit Adjustment Factor
- B. Rate Type
- C. Pricing Indicator
- D. Procedure Modifier

Which of the following statements about rate types are correct? (Select all that apply.)

- A. The Rate Type link is located in the Codes section of the **Related Data** panel.
- B. You click the add button to save a new rate type.
- C. The first step to create a new rate type is to click **add**.
- D. You complete the required information in the **Rate Type** panel after you click **add**.

Summary

In this lesson, you learned about the related data panels that you can use in order to add new options to the following rule parameter drop-down lists.

- **Pricing Indicator**
- **Rate Type**
- **Benefit Adjustment Factor**

Adding a Pricing Indicator

What

In this topic you learn how to add a pricing indicator. A pricing indicator describes the method by which MITS prices claims.

Who

An OHP staff member who is responsible for maintaining pricing information performs this task.

When

Perform this task when you need to establish a new pricing indicator for provider reimbursement.

Relevance

You must know how to add pricing indicators to apply accurate pricing to a provider reimbursement.

Requirements

A new pricing indicator requires additional programming in MITS beyond the functionality of the MITS panels.

Follow your local processes for submitting programming requests to complete the addition of the new pricing indicator.

How To

Follow these steps from the MITS home page to add a pricing indicator:

Step	Action
1	Click Reference .
2	Click related data .
3	Click Codes .
4	Scroll and click Pricing .
5	Click add .
6	Type the desired information in the applicable fields.
7	Click save .

Success

You have successfully completed this task when a confirmation message displays.

Next Steps

A new pricing indicator requires additional programming in the MITS system beyond the functionality of the MITS panels.

Follow your local processes for submitting programming requests in order to complete the addition of the new pricing indicator.

Practice

Add a pricing indicator using this information:

- **Pricing:** Use the code provided to you by the instructor.
- **Description:** Training Demonstration Code
- **HCPCS Procedure Indicator** = No

Summary

In this topic you learned how to add a pricing indicator.

Q&A

Adding a Rate Type

What

In this topic, you learn how to add a rate type to use for a provider reimbursement.

Who

An OHP staff member who is responsible for maintaining pricing information performs this task.

When

You perform this task whenever you need a new rate type to use for a provider reimbursement.

Relevance

You must add a rate type when the existing rate types do not apply. A new pricing policy, for example, may require a new rate type.

Requirements

- You must have the appropriate security role to perform this task.
- You must ensure the rate is associated with the appropriate rate type.

Guidelines

Just because you add a rate type, does not mean the rate type automatically connects with other parts of MITS; currently, you have to coordinate the next step with the Reference team.

How To

Follow these steps from the MITS home page to add a rate type:

Step	Action
1	Click Reference .
2	Click related data .
3	Click Codes .
4	In the Related Data panel, scroll and click Rate Type .
5	Click add .
6	Type the desired information in the fields.
7	Click save .

Success

You have successfully completed this task when a confirmation message displays indicating the rate type has been saved.

Practice

Add a rate type using this information:

- **Rate Type:** Use the rate type provided by the instructor
- **Description:** Training
- **Long Description:** Training Demonstration Code

Lastly, delete the same code you originally added throughout these tasks. (This allows you to use the same codes.)

Summary

In this topic you learned how to add a rate type.

Q&A

Adding a Benefit Adjustment Factor

What

In this topic, you learn how to add a benefit adjustment factor (BAF).



Some panels, such as the **Rule Summary** panel, refer to this only as an "Adjustment Factor."

Who

An OHP staff member who is responsible for maintaining pricing information performs this task.

When

You perform this task whenever a policy directive indicates the need for a new benefit adjustment factor.

Relevance

The Benefit Adjustment Factor (BAF) function provides the ability to alter an existing allowed amount by a set percentage, a series of percentages, or a dollar amount to increase or reduce the allowed amount by the percentage or dollar amount assigned.

This type of adjustment works in conjunction with pricing methodologies to apply a percentage to the allowed amount. This allows you to alter a rate using different criteria without having to create a new rate.

Requirements

You must have the appropriate security role to perform this task.

The Benefit Adjustment Factor panel has two sections: **Benefit Adjustment Factor Type** and **Benefit Adjustment Factor Rate**.

- Each section includes an **add** button.
- You must **first** add information in the **Benefit Adjustment Factor Type** section and **then immediately** add information in the **Benefit Adjustment Factor Rate** section.
- Do **not** click **save** until you complete **both** sections.
- If you input a rate, you **must** set the percentage as 100%.
- If you keep the Rate field as zero, you can use a different percentage.

Guidelines

You can name a BAF whatever you wish, but using the dollar amount or percentage amount for the name is recommended for ease of use.

How To

Follow these steps from the MITS home page to add a BAF:

Step	Action
1	Click Reference .
2	Click related data .
3	Click Other .
4	Click Benefit Adjustment Factor .
5	Click add in the Benefit Adjustment Factor Type section.
6	Type the desired information in the fields.
7	Click add in the Benefit Adjustment Factor Rate section.
8	Type the desired information in the fields.
9	Click save . Note: Do not click save until you have completed both sections (Benefit Adjustment Factor Type and Benefit Adjustment Factor Rate).

Success

You have successfully completed this task when a confirmation message displays indicating the BAF has been saved.

Practice

Add a benefit adjustment factor type using this information:

- **BAF Name:** Use the name provided by the instructor
- **Description:** Training Practice

Add a benefit adjustment factor rate using this information:

- **Rate:** Use the same value that use used for **BAF Name**.
- **Effective Date:** Enter Valid Date or accept default
- **End Date:** Enter Valid Date or accept default
- **Inactive Date:** 12/31/2299
- **Rate:** Enter Valid Rate or **Percent:** Enter Percentage

Summary

In this topic you learned how to add a benefit adjustment factor.

Q&A

Review

In this course you learned how to:

- View an existing reimbursement rule.
- Add and maintain reimbursement rules.
- Create a pricing indicator.
- Create a rate type.
- Create an adjustment factor.