

Ohio

**Medicaid Information
Technology System**

**State & Local Government Solutions
Medicaid Information Technology System (MITS)**

Claims, Edits, Audits, EOB Participant Guide

November 30, 2010

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

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Course Overview

The goal of this course is to provide you with the skills required to perform tasks associated with edits, audits, and Explanation of Benefit Codes (EOB).

Objective(s)

After completing this course you should be able to:

- Add, update, and delete edit dispositions
- Add, update, and delete audits
- Add, update, and delete Explanation of Benefit codes (EOB)

Agenda

Topic	Time
Welcome and Introductions	10 minutes
Introduction to Edits, Audits and Explanation of Benefit Codes	30 minutes
How to Add, Update, and Delete Edits	30 minutes
Break	15 minutes
How to Add, Update, and Delete Audits	40 minutes
How to Add, Update, and Delete EOBs	20 minutes

Introduction to Edits, Audits and Explanation of Benefit Codes

Overview

Edits and audits ensure that claims and claim detail abide by current policy criteria within the state of Ohio. Claims are processed against various edit and audit checks before the final adjudication and disposition of the claims.

The **edit** function verifies the accuracy, validity, required presence, format, consistency, allowable values, and integrity of data submitted. If an edit posts to a claim, an **Explanation of Benefit** (EOB) code designates the type of failure posted to the claim. **Audits** determine whether the service being billed has any policy restrictions based on other claims in history.

After a claim processes through edits and audits, MITS assigns a status known as the **disposition**. The correct claim detail disposition is determined by the claim type, outcome (full failure or cutback), provider specialty, date of receipt, and date of service of the claim.

Valid disposition values include:

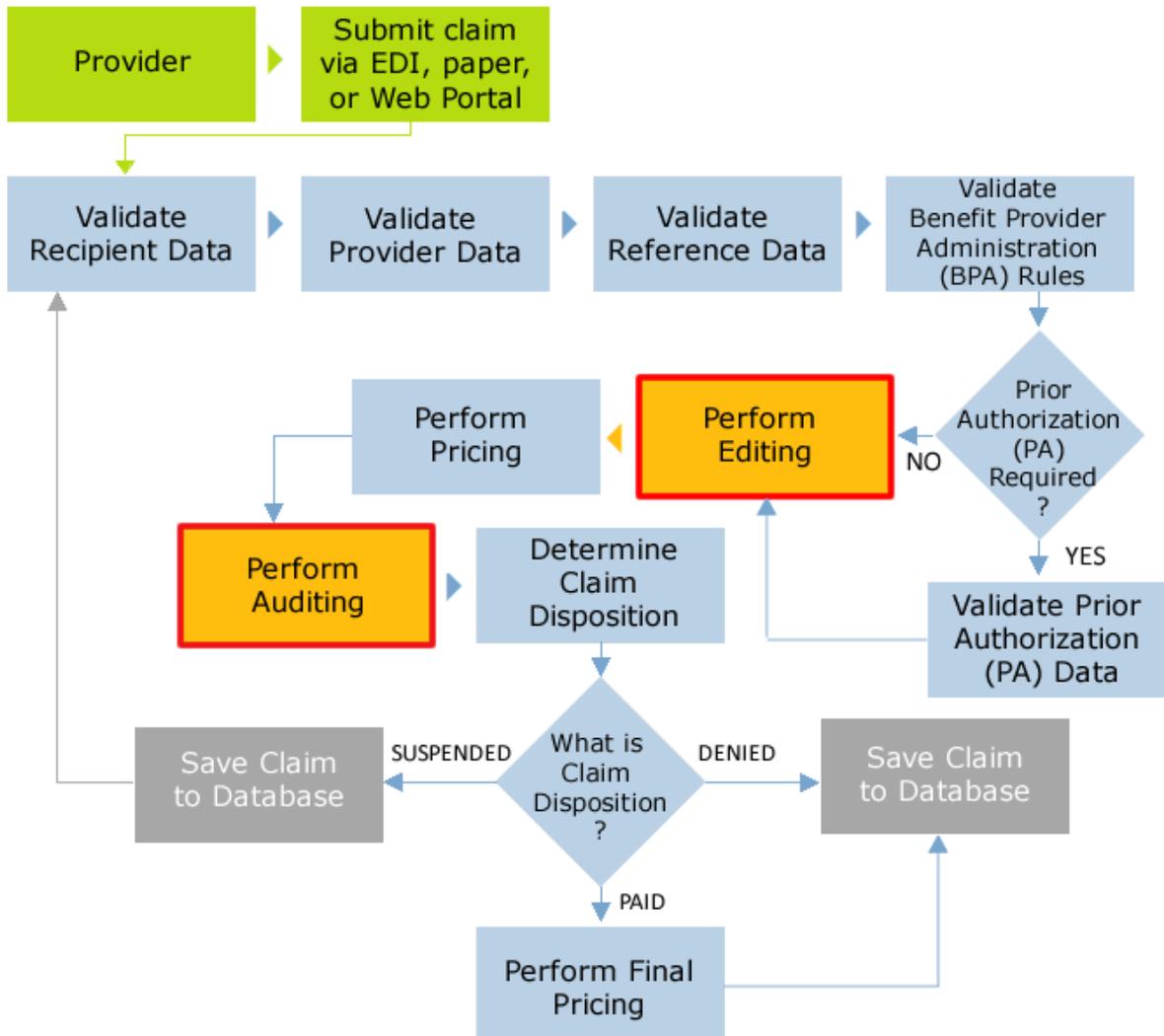
- Pay/Informational
- Suspended
- Denied
- Super-suspend
- Inactive



Edits that post against rule criteria are rule based edits.

Edits, Audits and Claim Adjudication

As claims are submitted and processed, the data on the claim is validated against a series of rules, edits, and audits. Review the flowchart below to follow the sequence in which claim data is processed to see where edits and audits impact the claim adjudication process.



Edits, Audits, and Ohio Medicaid Policy

Edits and audits both ensure that claims are processed in accordance with state policies. To recognize how edits and audits enforce Ohio Medicaid policy, review and contrast the characteristics of each:

Edit Characteristics

- Validates and verifies claim data
- Checks for presence, format, consistency, and reasonableness of data, as well as for allowable values
- Not configurable

Audit Characteristics

- Determines whether the service being billed has any policy restrictions based on other claims in history
- Compares the data of a claim in process with paid claims history data to determine the appropriateness of the service
- User-configurable and requires audit criteria and parameters

Review the table below to familiarize yourself with the Error System Codes (ESC) assigned to each edit category used by Ohio Department of Job Family Services (ODJFS).

Edit Type	Edit Description or Example	ESC Code Range
Form or Field	Required fields, required format for data, required data types.	0001-0999
Provider	Provider -specific edits, for example, verification of provider eligibility.	1000-1999
Recipient	Recipient-specific edits, for example, verification of recipient eligibility to receive reimbursement for services at the date of service.	2000-2999
Prior Authorization	Prior authorization related edits, for example, diagnosis and prior authorization conflict.	3000-3199
Reference	Edits related to benefit plans, contracts, reimbursement rules, assignment plans, and other related reference data.	3300-4999
Audits	Audits determine whether the service being billed has any policy restrictions based on other claims in history.	5000-6999
Miscellaneous	Miscellaneous edits, for example, long term care and nursing facility rate edits.	7010-7199

Audits and MITS

An audit validates claim data against other claims in history. An audit validation includes checking for:

- Duplicate services
- Exceeded service limits
- Exceeded “once-in-a-lifetime” services

Error Code: 5031
The standardized audit error code is between 5000 and 6999.

Base Information: Must be associated to a directive.

Audit Criteria Base: Include/Exclude indicators determine audit restrictions that can be set.

Audit criteria can be configured using one of the following categories:

- Benefit Limits
- Contra-Indicated
- Negative Contra-Indicated
- Umbrella
- Conflict Audit

To learn more about the categories, review the descriptions and examples below:

Audit Category	Audit Category Description	Example
Benefit Limits	Sets dollar or unit limitations on services (procedure code, revenue code) based on defined criteria.	Limiting the number of physical therapy visits to 30 per year. In this example, you can look up the specific recipient to see if the recipient exceeded the limit.
Contra-Indicated	Limits services based on relationships between procedure codes on history and the procedure codes on the current claim detail.	Submitting a tooth restoration claim after a tooth extraction claim. In this example, MITS rejects the tooth restoration claim.
Negative Contra-Indicated	Limits services based on the absence of prior procedure codes in history.	Submitting a labor code without the corresponding material code or a surgery code without an anesthesia code. In these examples, MITS rejects the claims.
Umbrella	Limits pre-operative and post-operative care for surgical procedures. The surgical procedures that apply to a specific umbrella audit are identified by the number of days in the global surgery field on the Medicare fee schedule. The pre-operative and post-operative care procedures are defined on the audit criteria.	Submitting a separate follow up visit procedure within 30 days after surgery. In this example, MITS rejects the claim for the follow up visit.
Conflict Audit	Compares dates between services on different claim types to verify that there are no conflicting services for overlapping dates.	Submitting a long term care claim for the same dates of service as a home health care claim that in history. In this example, MITS denies the long term care claim.

Configuring Audits

To configure various audit definitions, use the **Inclusion/Exclusion** Indicators as well as the **Same/Different** Indicators. The **Include/Exclude** indicators designate whether an attribute should be included. For example, setting the indicator to **Include** indicates the audit will set when those attributes are present, assuming all other criteria are met. Setting the indicator to **Exclude**, indicates the audit would be bypassed for those attributes, and set for all other attributes that were not excluded.

The **Same/Different/Both** indicators are used to determine which claims in history will be used in the audit. For example, setting an indicator to **Same**, indicates that a history claim will be used only if the procedure code matches the one used on the current claim. Setting the indicator to **Different**, indicates a history claim will be used only if the procedure code does **not** match the code on the current claim. Setting the indicator to **Both**, indicates there is no limitation and history claims with all procedure codes will be used in the audit.



Setting the **Include/Exclude** Indicator section requires an accompanying audit restriction for the attribute that is included or excluded.

Review the panels to learn more about using the Audit panels and the corresponding indicators.

Configuring Audits

1 Error Code: The standardized audit error code is between 5000 and 6999.

2 Each audit must be configured with the appropriate Audit Parameters (under Audit Criteria) in order to save. A minimum Audit Restriction (Include/Exclude Indicators) is not required.

3 Base Information: Must be associated to a directive.

4 Audit Criteria Base: Include/Exclude indicators determine audit restrictions that can be set.

Configuring Audits

Audit Criteria Base

*Audit Type: BL - BENEFIT LIMITS

*Effective Date: 06/24/2010

*End Date: 12/31/2299

Include/Exclude Indicators

*Recipient Plan: None

*Claim Type: None

*Provider Type: None

*Provider Specialty: None

*Recipient Age: Include

*Procedure: **Exclude**

*Diagnosis: None

*Revenue Code: None

*Type of Bill: None

*Financial Payer: None

*Incl/Excl Modifier: None

*Provider Contract: None

*Limit Parameter POS: None

Same/Different Indicators

*Claim: Both

*Date of Service: Both

*Financial Payer: Both

*Provider: Both

*Procedure: Both

*Diagnosis: Both

*Tooth Number: Both

*Tooth Surface: Both

*Tooth Quadrant: Both

*Same/Diff Modifier: Both

Other Indicators

*Gender: Both

*PA Override: NO

Match J Codes: NO

*Service Limit: NO

*Referral Override: Not Considered

*Diagnosis Type: N/A

5 Select Include or Exclude in the Indicators column to be able to set the corresponding restriction.

Configuring Audits

Audit Criteria Base

*Audit Type: BL - BENEFIT LIMITS

*Effective Date: 06/24/2010

*End Date: 12/31/2299

Include/Exclude Indicators

*Recipient Plan: None

*Claim Type: None

*Provider Type: **Exclude**

*Provider Specialty: None

*Recipient Age: None

*Procedure: None

*Diagnosis: None

*Revenue Code: None

*Type of Bill: None

*Financial Payer: None

*Incl/Excl Modifier: None

*Provider Contract: None

*Limit Parameter POS: None

Same/Different Indicators

*Claim: Both

*Date of Service: Both

*Financial Payer: Both

*Provider: **Different**

*Procedure: Both

*Diagnosis: Both

*Tooth Number: Both

*Tooth Surface: Both

*Tooth Quadrant: Both

*Same/Diff Modifier: Both

Other Indicators

*Gender: Both

*PA Override: NO

Match J Codes: NO

*Service Limit: NO

*Referral Override: Not Considered

*Diagnosis Type: N/A

6 This type of audit, using the **exclude** and **different** for provider attribute, will exclude the benefit limit audit for providers that are different than the provider that is specified.

Configuring Audits

Audit Criteria Base

*Audit Type: BL - BENEFIT LIMITS

*Effective Date: 06/24/2010

*End Date: 12/31/2299

Include/Exclude Indicators

*Recipient Plan: None

*Claim Type: None

*Provider Type: **Exclude**

*Provider Specialty: None

*Recipient Age: None

*Procedure: None

*Diagnosis: None

*Revenue Code: None

*Type of Bill: None

*Financial Payer: None

*Incl/Excl Modifier: None

*Provider Contract: None

*Limit Parameter POS: None

Same/Different Indicators

*Claim: Both

*Date of Service: Both

*Financial Payer: Both

*Provider: **Both**

*Procedure: Both

*Diagnosis: Both

*Tooth Number: Both

*Tooth Surface: Both

*Tooth Quadrant: Both

*Same/Diff Modifier: Both

Other Indicators

*Gender: Both

*PA Override: NO

Match J Codes: NO

*Service Limit: NO

*Referral Override: Not Considered

*Diagnosis Type: N/A

7 This type of audit, using the **exclude** and **both** attribute, will exclude the benefit limit audit for all providers.

Configuring Audits

Audit Criteria Base

*Audit Type: BL - BENEFIT LIMITS

*Effective Date: 06/24/2010

*End Date: 12/31/2299

Include/Exclude Indicators

*Recipient Plan: None

*Claim Type: None

*Provider Type: **Include**

*Provider Specialty: None

*Recipient Age: None

*Procedure: None

*Diagnosis: None

*Revenue Code: None

*Type of Bill: None

*Financial Payer: None

*Incl/Excl Modifier: None

*Provider Contract: None

*Limit Parameter POS: None

Same/Different Indicators

*Claim: Both

*Date of Service: Both

*Financial Payer: Both

*Provider: **Same**

*Procedure: Both

*Diagnosis: Both

*Tooth Number: Both

*Tooth Surface: Both

*Tooth Quadrant: Both

*Same/Diff Modifier: Both

Other Indicators

*Gender: Both

*PA Override: NO

Match J Codes: NO

*Service Limit: NO

*Referral Override: Not Considered

*Diagnosis Type: N/A

8 This type of audit, using the **include** and **same** for provider attribute, will include the benefit limit audit for providers that match the provider that is specified.

Explanation of Benefit Codes

An EOB code is a notice issued to a provider that explains in detail the payment or nonpayment of a specific claim that is processed. EOB codes offer providers detail information on claim header and/or detail. The code prints on the remittance advice to communicate why a claim was either denied or suspended. In addition, EOB codes provide additional information on claim adjudication.

The image illustrates a sample EOB code associated with an audit restriction.

Disposition Criteria											Top
Line Number	Claim Type	Recipient Plan	Disposition Status	Outcome Code	Claim Location	Financial Payer	Provider Type	Provider Specialty	Effective DOR	Effective DOS	
1	0 - ALL CLAIM TYPES	ALL	Inactive	Full Failure	01 - General suspense-default location	ALL plans	00	000	01/01/1994	01/01/1994	
2	M - CMS 1500 CLAIMS	ALL	Inactive	Full Failure	01 - General suspense-default location	ALL plans	00	000	01/01/1994	01/01/1994	

Type changes below.

Line Number	1	*Claim Type	0 - ALL CLAIM TYPES
Provider Type	00 [Search]	Recipient Plan	ALL - All Benefit Plans
*Provider Specialty	000 [Search]	*Claim Location	01 - General suspense-default location
*Print Type	Do not report	*Disposition Status	Inactive
*Print on RA	Yes	*Outcome Code	Full Failure
Effective DOR	01/01/1994	Financial Payer	ALL ALL plans
Effective DOS	01/01/1994		

delete

Region Data--							Type changes below.
Region	Region Description	EOB	Financial Payer	Disposition Status Code	Dispo	Descr	
00 - ALL CLAIM REGIONS	ALL CLAIM REGIONS	5031	ALL plans	D - DENY	DENY		
10 - PAPER CLAIMS WITH NO ATTACHMENTS	PAPER CLAIMS WITH NO ATTACHMENTS	9998	ALL plans	S - SUSPEND	SUSP		
11 - PAPER CLAIMS WITH ATTACHMENTS	PAPER CLAIMS WITH ATTACHMENTS	9998	ALL plans	S - SUSPEND	SUSP		
55 - MASS ADJUSTMENTS - PROVIDER RETRO RATES	MASS ADJUSTMENTS - PROVIDER RETRO RATES	5031	ALL plans	P - PAY/INFORMATIONAL	PAY/		
80 - CLAIMS REPROCESSED BY MITS SYSTEMS ENGINEERS	CLAIMS REPROCESSED BY MITS SYSTEMS ENGINEERS	9998	ALL plans	S - SUSPEND	SUSP		
90 - SPECIAL PROJECTS	SPECIAL PROJECTS	9998	ALL plans	S - SUSPEND	SUSP		
91 - BATCHES REQUIRING MANUAL REVIEW	BATCHES REQUIRING MANUAL REVIEW	9998	ALL plans	S - SUSPEND	SUSP		
97 - SINGLE RESUBMISSION	SINGLE RESUBMISSION	9998	ALL plans	S - SUSPEND	SUSP		
98 - MASS RESUBMISSION	MASS RESUBMISSION	9998	ALL plans	S - SUSPEND	SUSP		

Region	10 - PAPER CLAIMS WITH NO ATTACHMENTS	Financial Payer	ALL ALL plans
Disposition Status	S - SUSPEND	*EOB	9998

CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR

EOB: EOB codes must appear with all edits and audit.

Edit and Audit Reports

Review the reports on an ongoing basis to monitor claim suspensions, adjustments, denials and other data related to existing edits and audits.

Report Title	Report Objective
Suspense File Analysis by Exception Code	Lists all occurrences of each exception code in the file of suspended claims. This report is derived from claim types within the following ranges: <ul style="list-style-type: none"> • Dental • Pharmacy • Phys • UB04
Daily Exception Summary by Claim Type	Lists how many times an exception occurred, grouped by claim type.
Daily Edit Audit - Five Day Cycle Summary by Claim Type	Lists how many times an exception occurred. This report is grouped by claim type for the last five cycles.
Top Denial Weekly by Claim Type Report	Lists the top twenty error codes of the denied claims grouped by claim type for the week.
Top Denial Quarterly by Claim Type Report	Lists the top twenty error codes for the denied claims grouped by claim type for the quarter.
Daily Exception Summary by Claim Type Original Claims	Lists how many times each exception occurred for original claims in the last five cycles, sorted by claim type.
Daily Exception Summary by Claim Type Adjustments	Lists how many times each exception occurred for adjusted claims in the last five cycles, sorted by claim 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.

Denying a claim submitted for a separate follow-up visit within 30 days after surgery is an example of what type of audit?

- A. Benefit Limit
- B. Umbrella
- C. Contra-Indicated
- D. Negative Contra-Indicated

One difference between an edit and audit is that an audit can be configured while an edit is not configurable.

- A. True
- B. False

Audits may be configured using any of the following attributes. Select all that apply.

- A. Claim Type
- B. Recipient Plan
- C. Provider Type
- D. Provider Location

Summary

In this lesson, you learned how edits, audits and EOB codes impact the adjudication of claims. You also learned how to configure edit dispositions and audits and how to review associated reports.

Maintaining Edit Dispositions

Overview

What

In this topic you learn how to add, update and delete edit dispositions, i.e., configuration and dispositions of an edit. Edits review data on a claim against system data to determine whether the data meets set requirements, for example, format, consistency, justification, and allowable values.

Who

The Error Disposition Resolution Specialist within the Reference Data Maintenance group is responsible for maintaining edit dispositions.

When

This task is performed when the state of Ohio initiates a Change System Request (CSR) to add, delete, or update edit dispositions in MITS.

Relevance

This task is important because it allows for claims to be adjudicated based on the most current state policies. Policies are implemented through the edits that define dispositions for all parameters in a claim which are processed against the edit criteria.

Requirements

- A directive must be selected to add, change or delete an edit disposition.
- There must be a unique Error System Code (ESC) assigned to each edit disposition.
- All ESCs must have an associated EOB.
- For every ESC, the associated EOB must be linked to a HIPAA Claim Status Code and a HIPAA entity ID.

Guidelines

In order to perform this task, you must be aware of the most current state policies and how claim edits must be dispositioned.

Adding Edit Dispositions

Follow these steps from the MITS home page to add an edit, i.e., error disposition:

Step	Action
1	Select Error Disposition from the Reference drop-down list.
2	Click add .
3	Select a directive from the Directive Version drop-down list.
4	Complete the Error Code field.
5	Complete the Description field.
6	Add at least one line to the Disposition Criteria panel.
7	Complete the following required fields in the Disposition Criteria panel: <ul style="list-style-type: none"> • Print on RA • Print Type • Outcome Code • Claim Location • Recipient Plan • Claim Type • DOR <i>or</i> DOS
8	Add at least one line to the Region Data section of the Disposition Criteria panel.
9	Complete the following required fields in the Region Data section of the Disposition Criteria panel: <ul style="list-style-type: none"> • Region • Disposition Status • EOB
10	Click Save in the Maintenance panel

Updating Edit Dispositions

Follow these steps from the MITS home page to update an edit, i.e., error disposition:

1.	Select Error Disposition from the Reference drop-down list.
2.	Type the error code associated to the error disposition.
3.	Click search .
4.	Select a directive from the Directive Version drop-down list.
5.	Click Disposition Criteria .
6.	Click the disposition line number to update.
7.	Update disposition criteria information as needed.
8.	To update region data associated to the error disposition, click the Region Data line number to update.
9.	Update the disposition status or EOB code accordingly.
10.	Click save .

Deleting Edit Dispositions

Follow these steps from the MITS home page to delete an edit, i.e., error disposition:

Step	Action
1	Select Error Disposition from the Reference drop-down list.
2	Type the error code associated to the error disposition.
3	Click delete .
4	Click Ok .

Success

You have successfully added, deleted, or updated an edit disposition if the message “Save Was Successful” displays in the Message Description. After a claim is processed through edits, a disposition status is assigned to the claim header or detail. The correct claim detail disposition is determined by the claim type, outcome (full failure or cutback), provider specialty, date of receipt, and date of service of the claim.

Next Steps

Test the edit disposition in the appropriate environment, for example, the model office environment. Then promote the edit disposition to the production environment. The edit disposition will ensure that claims that do not satisfy program or processing requirements specified in the edit criteria are adjudicated according to state policy.

Practice

Create an edit disposition for all claims and locations using this information:

- **Directive** = CNV2009
- **Error Code** = Students should use one of the codes supplied below, as assigned by the instructor.

Note: This code was selected due to availability for practice, and may not be within the pre-determined, code ranges described in the lesson.

Student	Use this Code...	Student	Use this Code...
1	402	16	523
2	403	17	524
3	431	18	531
4	439	19	534
5	441	20	535
6	452	21	536
7	478	22	537
8	490	23	538
9	494	24	539
10	497	25	540
11	498	26	541
12	501	27	542
13	504	28	543
14	515	29	544
15	517	30	547

- **Print Type** = Pay and Report
- **Print on RA**= Yes
- **Claim Type** = 0-All Claim Types
- **Effective DOS** = 10/7/10
- **Recipient Plan** = MCAID – Medicaid
- **Claim Location** = 00- All Locations
- **Outcome Code** = Cutback
- **Region** = 0 – All claim regions
- **Disposition Status**= S - Suspend
- **EOB** = Search for, and select an EOB of your choice.

When you have completed creating the edit disposition, update the disposition status to D-Deny.

After you update the status, delete the edit disposition.

After successfully adding, updating, and deleting the edit disposition, be prepared to describe what appears on the line item in the **Disposition Criteria** panel.

Summary

In this topic you learned how to add, update, and delete edit dispositions.

Maintaining Audit Restrictions

Overview

What

In this topic you learn how to add, update, and delete an audit restriction. An audit validates and verifies claim data against other claims in history. The validation includes checks for duplicate services, service limits that were exceeded, and duplicate billing for services. The types of audits in MITS are as follows:

- Duplicate Checking
- Limitation
- Negative Contra-Indicated
- Umbrella
- Conflict audit

Who

The Error Disposition Resolution Specialist is responsible for adding, updating, and deleting audits.

When

This task is performed when the state of Ohio initiates a Change System Request (CSR) to add, update or delete an audit.

Relevance

This task is important because it allows for claims to be adjudicated based on the most current state policies. These policies are implemented through the audit criteria that define dispositions for all parameters in a claim which are processed against the audit criteria.

Requirements

- Each audit must have the following:
 - Base Information
 - Disposition Criteria with at least one claim type row and one region row
 - Audit Criteria
 - Audit Parameters
- All Limitation audits and any edits that can perform cutbacks of units and/or dollars require a disposition line with an Outcome code of CUTBACK in addition to the disposition line with an Outcome code of FULL FAILURE. The CUTBACK disposition line must match exactly the FULL FAILURE disposition line.
- A directive must be selected to add an audit.
- There must be a unique ESC assigned to each audit.
- The Explanation of Benefit EOB code for the edit/audit must be available prior to entering the information on the Adjustment/Data Correction EOB panel.
- Diagnosis restrictions must include a valid diagnosis from and diagnosis to code.

Guidelines

In order to perform this task, you must be aware of the following tips:

- Panel edits confirm that all required fields for each audit type are completed. You cannot save an audit if the system edit identifies an error.
- The most common audit restrictions incorporate either procedure, claim type, provider or date of service components.

Include/Exclude Indicators designate whether an attribute should be included, for example, the audit will set when those attributes are present, assuming all other criteria are met. Setting the indicator to excluded bypasses the audit, for example, the audit would be bypassed for those attributes, and set for all other attributes that were not excluded.

- **Include** – sets the attribute if all other criteria are met
- **Exclude** – bypasses the audit for those attributes

Same/Different Indicators determine which claims in history are used in the audit based on the following settings:

- **Same** – history claim is used only if the procedure code matches the one used on the current claim.
- **Different** – history claim is used only if the procedure code DOES NOT match the one used on the current claim.
- **Both** – history claims with all procedure codes are used in the audit and there is no limitation.

Adding an Audit

Follow these steps from the MITS home page to add an audit:

Step	Action
1	Select Error Disposition from the Reference drop-down list.
2	Click add .
3	Select a directive from the Directive Version drop-down list and type the error code, error description and all relevant required and optional audit base information.
4	Click add and complete at least one row of disposition criteria information.
5	Click add and complete at least one row of region data information and include a valid EOB.
6	Click Audit Criteria .
7	Click add and select the audit type from the Audit Type drop-down list. Note: Contra and Negative contra audit parameters specify whether the audit is a one-way or two-way audit. In addition, Contra and Negative contra audit parameters specify whether the specified time limit should be checked for services before, after, or before and after the current claim.
8	Set the Include/Exclude Indicators and Same/Different Indicators according to the required parameters.
9	Click Audit Parameters .
10	Click Add and select the applicable information from the required and optional drop-down lists based on the audit type you selected.
11	Click Audit Restriction to review and update the criteria you specified by clicking the corresponding panels that are bold. Note: Only audit criteria that was specified will be bold to indicate that the corresponding panel may be selected.

Step	Action																								
12	<p data-bbox="318 279 987 317">Specify audit restrictions by following these steps:</p> <table border="1" data-bbox="375 363 1377 1803"> <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">Add minimum and maximum age restrictions</td> <td data-bbox="727 415 1377 562"> a. Click add. b. Type the minimum and maximum age in the corresponding fields. c. Click Save. </td> </tr> <tr> <td data-bbox="375 562 727 709">Add financial payer restrictions</td> <td data-bbox="727 562 1377 709"> a. Click Add. b. Select the applicable financial payer option from the drop-down list. c. Click Save. </td> </tr> <tr> <td data-bbox="375 709 727 821">Add procedure restrictions</td> <td data-bbox="727 709 1377 821"> a. Click Add. b. Type the applicable procedure code restrictions. c. Click Save. </td> </tr> <tr> <td data-bbox="375 821 727 932">Add provider type restrictions</td> <td data-bbox="727 821 1377 932"> a. Click Add. b. Type the applicable provider code. c. Click Save. </td> </tr> <tr> <td data-bbox="375 932 727 1043">Add type of bill restrictions</td> <td data-bbox="727 932 1377 1043"> a. Click Add. b. Type the applicable type of bill code. c. Click Save. </td> </tr> <tr> <td data-bbox="375 1043 727 1155">Add claim type restrictions</td> <td data-bbox="727 1043 1377 1155"> a. Click Add. b. Add claim type restrictions c. Click Save. </td> </tr> <tr> <td data-bbox="375 1155 727 1297">Add limit parameter place of service restrictions</td> <td data-bbox="727 1155 1377 1297"> a. Click Add. b. Type the POS code or search for the code to include or exclude from the limit audit. c. Click Save. </td> </tr> <tr> <td data-bbox="375 1297 727 1440">Add provider contract restrictions</td> <td data-bbox="727 1297 1377 1440"> a. Click Add. b. Select the applicable provider contract from the Provider Contract drop-down list. c. Click Save. </td> </tr> <tr> <td data-bbox="375 1440 727 1583">Add recipient plan restrictions</td> <td data-bbox="727 1440 1377 1583"> a. Click Add. b. Select the applicable recipient plan from the Recipient Plan drop-down list. c. Click Save. </td> </tr> <tr> <td data-bbox="375 1583 727 1726">If you want to add limit parameter place of service restrictions</td> <td data-bbox="727 1583 1377 1726"> a. Click Add. b. Type the POS code or search for the code to include or exclude from the limit audit. c. Click Save. </td> </tr> <tr> <td data-bbox="375 1726 727 1803">If you want to add diagnosis restrictions</td> <td data-bbox="727 1726 1377 1803"> a. Click Add. b. Specify the diagnosis from and diagnosis to </td> </tr> </tbody> </table>	TO:	THEN:	Add minimum and maximum age restrictions	a. Click add . b. Type the minimum and maximum age in the corresponding fields. c. Click Save .	Add financial payer restrictions	a. Click Add . b. Select the applicable financial payer option from the drop-down list. c. Click Save .	Add procedure restrictions	a. Click Add . b. Type the applicable procedure code restrictions. c. Click Save .	Add provider type restrictions	a. Click Add . b. Type the applicable provider code. c. Click Save .	Add type of bill restrictions	a. Click Add . b. Type the applicable type of bill code. c. Click Save .	Add claim type restrictions	a. Click Add . b. Add claim type restrictions c. Click Save .	Add limit parameter place of service restrictions	a. Click Add . b. Type the POS code or search for the code to include or exclude from the limit audit. c. Click Save .	Add provider contract restrictions	a. Click Add . b. Select the applicable provider contract from the Provider Contract drop-down list. c. Click Save .	Add recipient plan restrictions	a. Click Add . b. Select the applicable recipient plan from the Recipient Plan drop-down list. c. Click Save .	If you want to add limit parameter place of service restrictions	a. Click Add . b. Type the POS code or search for the code to include or exclude from the limit audit. c. Click Save .	If you want to add diagnosis restrictions	a. Click Add . b. Specify the diagnosis from and diagnosis to
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Updating an Audit

Follow these steps from the MITS home page to modify an audit:

Step	Action
1	Select Error Disposition from the Reference drop-down list.
2	Type the error code in the Error Code field and click Search . Note: You can specify a range of error codes by completing the Error Code From and Error Code To fields.
3	Click Audit Criteria and proceed to update the applicable fields: <ul style="list-style-type: none"> • Update the Effective Date and End Date fields, if appropriate. • Use the drop-down menus to modify the Include/Exclude Indicators fields as needed. • Use the drop-down menus to complete the Same/Different Indicators fields as needed.
4	Click Audit Parameters .
5	Select a directive from the Directive Version drop-down list.
6	Modify the Include/Exclude indicators and Same/Different Indicators according to the required parameters.
7	Click Audit Restriction and click the corresponding panel(s) in bold to update the appropriate restrictions in the panels below.
8	Click Save .

Deleting an Audit

Follow these steps from the MITS home page to delete an audit:

Step	Action
1	Select Error Disposition from the Reference drop-down list.
2	Type the error code in the Error Code field and click Search . Note: You can specify a range of error codes by completing the Error Code From and Error Code To fields.
3	Select a directive from the Directive Version drop-down list.
4	Click Delete .
5	Click Save .

Success

You have successfully added, updated, or deleted audit restrictions if the message “Save Was Successful” displays in the Message Description. After a claim is processed through audits it is assigned a status known as the disposition. A valid disposition value for an audit is “denied”. A disposition of “paid” can incorporate a partial payment based on a denial of one or more services.

Next Steps

Test the audit change in the appropriate environment, for example, the configuration or model office environment. Then promote the audit restriction to the production environment. The audit will ensure that claims that do not satisfy program or processing requirements are adjudicated according to state policy.

Practice #1

Create an audit disposition for all claims and locations using this information:

- **Directive** = CNV2009
- **Error Code** = Students should use one of the codes supplied below, as assigned by the instructor.

Student	Use this Code...	Student	Use this Code...
1	5016	16	5058
2	5017	17	5059
3	5022	18	5060
4	5027	19	5101
5	5028	20	5102
6	5031	21	5103
7	5033	22	5104
8	5034	23	5105
9	5035	24	5106
10	5036	25	5107
11	5037	26	5108
12	5038	27	5109
13	5042	28	5110
14	5056	29	5111
15	5057	30	5112

- **Print Type** = Pay and Report
- **Print on RA**= Yes
- **Claim Type** = 0-All Claim Types
- **Effective DOS** = 10/7/10
- **Recipient Plan** = MCAID
- **Claim Location** = 00- All Locations
- **Outcome Code** = Cutback
- **Region** = 0 – All claim regions
- **Disposition Status**= S - Suspend
- **EOB** = 3000 or another EOB number of your choice
- **Audit Type**=Benefit Limit
- **Recipient Age** - Include
- **Age Minimum** – 3
- **Age Maximum** – 100

After creating the audit, update the claim type audit restriction by setting the Recipient Age to **Exclude**. Then delete the claim type audit restriction.

When you are done adding, updating, and deleting the audit, be prepared to describe what appears on the Claim type panel.

Practice #2

Create an audit disposition for all claims and locations using this information:

- **Directive** = CNV2009
- **Error Code** = Students should use one of the codes supplied below, as assigned by the instructor.

Student	Use this Code...	Student	Use this Code...
1	5113	16	5128
2	5114	17	5129
3	5115	18	5130
4	5116	19	5131
5	5117	20	5132
6	5118	21	5133
7	5119	22	5134
8	5120	23	5135
9	5121	24	5136
10	5122	25	5137
11	5123	26	5138
12	5124	27	5139
13	5125	28	5140
14	5126	29	5141
15	5127	30	5142

- **Print Type** = Pay and Report
- **Print on RA** = Yes
- **Claim Type** = 0-All Claim Types
- **Effective DOS** = 10/7/10
- **Recipient Plan** = MCAID – Medicaid
- **Claim Location** = 0-All
- **Recipient Plan** = MCAID
- **Claim Location** = 00- All Locations
- **Outcome Code** = Cutback
- **Region** = 0 – All claim regions **Disposition Status** = S - Suspend
- **EOB** = Search for, and choose an EOB
- **Audit Type** = Conflict Audit
- **Current Claim Type** – Dental Claims
- **History Claim Type** – Dental Claims
- **Conflict Indicator** – Yes

After creating the audit, update the claim type audit restriction by setting the conflict indicator to **no**. Then delete the claim type audit restriction.

When you are done adding, updating, and deleting the audit, be prepared to describe what appears on the Claim type panel.

Summary

In this topic you learned how to add, update, and delete audit restrictions.

Maintaining Explanation of Benefit (EOB) Codes

Overview

What

This task is about how to add Explanation of Benefit (EOB) codes. All edits and audits have an associated EOB to report the policy rule decision on the provider's Remittance Advice statement.

Who

The General Reference Update role within the Ohio Department of Job Family Services (ODJFS) is responsible for maintaining EOBs.

When

This task is performed when a member of the Ohio Department of Job Family Services (ODJFS) staff receives a CSR form to update an EOB code.

Relevance

This task is important because it disperses information related to claim adjudication to affected providers. The EOB explains why or how a claim was paid, suspended or denied.

Requirements

In order to complete this task, you must be aware of the following rules:

- All error status codes must have an associated EOB.
- Each EOB will need to be linked to a HIPAA Claim Status Code and a HIPAA entity ID.

Guidelines

In order to perform this task, you must be aware of the following guidelines:

- Each EOB will be associated to a HIPAA Adjustment reason code and remark code.
- Changes to EOB codes need to be made in the appropriate environment before being promoted to the production environment.

Adding an EOB

Follow these steps from the MITS home page to add an EOB:

Step	Action
1	Select Related Data from the Reference drop-down list.
2	Click Other .
3	Click EOB .
4	Click add .
5	Complete the required information.
6	Click save .

Updating an EOB

Follow these steps from the MITS home page to modify an EOB:

Step	Action
1	Select Related Data from the Reference drop-down list.
2	Click Other .
3	Click EOB .
4	Type the EOB code in the EOB field.
5	Click search .
6	Update the applicable fields.
7	Click save .

Deleting an EOB

Follow these steps from the MITS home page to delete an EOB:

Step	Action
1	Select Related Data from the Reference drop-down list.
2	Click Other .
3	Click EOB .
4	Type the EOB code in the EOB field.
5	Click search .
6	Click delete .
7	Click OK to confirm the deletion.

Success

You have successfully updated and EOB code if the message "EOB -Save Was Successful" displays in the Message Description.

Next Steps

Test the change in the model office environment and then promote the change to the configuration and production environments.

Practice

- **EOB** – Use the code highlighted below:

Student	Use this Code...	Student	Use this Code...
1	9018	16	9035
2	9019	17	9037
3	9020	18	9038
4	9021	19	9041
5	9022	20	9042
6	9023	21	9043
7	9024	22	9044
8	9025	23	9045
9	9026	24	9046
10	9027	25	9047
11	9028	26	9049
12	9029	27	9052
13	9032	28	9053
14	9033	29	9054
15	9034	30	5142

- **Effective Dates** – 1/1/1997 – 10/1/2006
- **HIPAA Claim Status Code** - 189
- **HIPAA Entity ID** - 85
- **Adjustment Reason Code** - B7
- **HIPAA Remarks Code** - MA03

After saving the EOB, update the start date, save the change and then delete the code. Be prepared to describe what needs to be associated to an EOB code.

Summary

In this topic you learned how to add, update, and delete EOB codes.

Review

Objectives

In this course you learned how to:

- Add, update, and delete edit dispositions
- Add, update, and delete audits
- Add, update, and delete EOB codes