



Medicaid Information Technology System

State & Local Government Solutions

Medicaid Information Technology System (MITS)

Provider Contracts Participant Guide

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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 provider contracts in Ohio MITS. You will learn how to configure and maintain provider contract rules. You will also learn how the rules relate to the edits/audits in the claims engine.



Objective(s)

After completing this course you should be able to:

- Define provider contracts as they relate to MITS and OHP policy
- Navigate to the provider contract panel
- View an existing provider contract
- Create and name a new provider contract
- Update a provider contract
- Navigate to/assign/deselect provider type/specialties for a provider contract
- Add and maintain the provider contract/claim type crosswalk
- Add and maintain provider contract group types
- Search for rules within provider contracts and the benefit groups
- Add, update, and delete rules for provider contracts
- Save rules
- Modify diagnosis editing for provider contract rules
- Update modifier editing for provider contract rules
- View the Conflict Report and correct any errors

Agenda

Topic	Time
Welcome and Introductions	5 minutes
Introduction to Provider Contracts	25 minutes
Maintaining Provider Contracts	25 minutes
Break	10 minutes
Introduction to Rules	25 minutes
Searching for Rules	25 minutes
Break	10 minutes
Save Process	10 minutes
Creating and Saving Rules	20 minutes
Rule Options	15 minutes
Updating/modifying rules data	15 minutes
Lunch	50 minutes
Introduction to Rule Diagnosis editing	10 minutes
Configuring Rule Diagnoses	20 minutes
Introduction to Rule Modifier editing	10 minutes
Configuring Rule Modifiers	20 minutes
Break	10 minutes
Introduction to Removing Rules	10 minutes
Excluding/Inactivating Rules	15 minutes
Introduction to Conflict Report Errors	10 minutes
Correcting Conflict Report Errors	15 minutes
Break	10 minutes
Introduction to Provider Contract Groups	10 minutes

Maintaining Provider Contract Groups	15 minutes
Introduction to Provider Contract Claim Types	10 minutes
Maintaining Provider Contract Claim Types	15 minutes
Review	5 minutes

Introduction to Provider Contracts

Overview

This lesson introduces you to provider contracts - a new feature in MITS. In OHP MMIS, provider contracts do not exist.



Importance of Provider Contracts

A provider contract lists the services that a provider can perform and/or bill for under Ohio Medicaid. An enrolled provider **must** be assigned to a provider contract. A provider may be enrolled in multiple provider contracts but **must** be assigned to at least one provider contract.

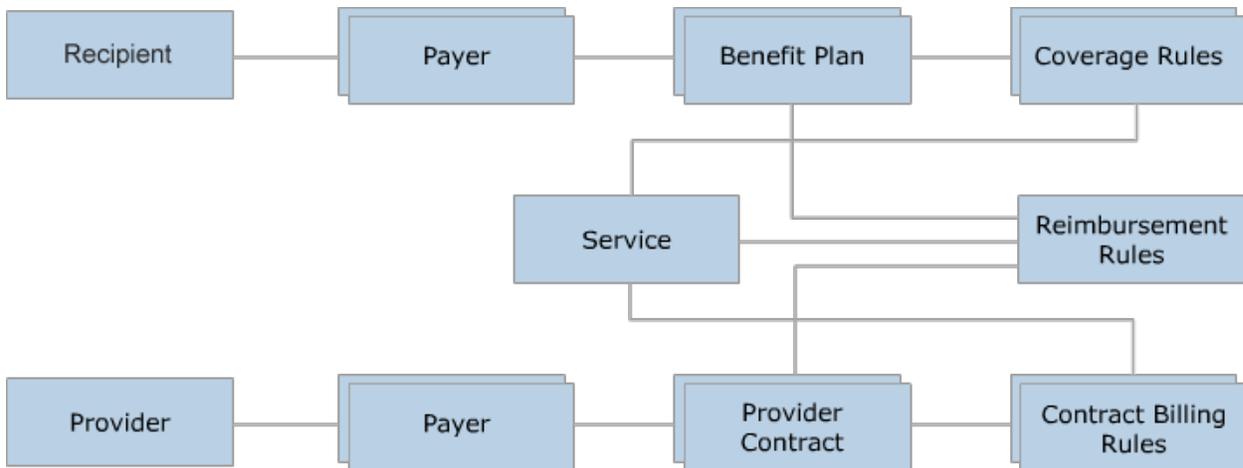
Provider contracts are important because they:

- Consolidate benefits a provider can bill for or perform and define the associated restrictions.
- Define an associated benefit classification and specific rules for at least one benefit in the classification.
- Define which provider types and specialties belong to each provider contract.
- Identify restrictions or conditions in the rules surrounding service delivery.

Sometimes provider types and specialties are candidates for contracts, as well as the category of services. In MITS, you can maintain for each contract a list of valid provider types/provider specialty combinations that are valid for the provider contract. It is mandatory to assign PT/PS to a contract in order for a contract to be available.

In addition, the provider contract tasks can and should be performed concurrently with the tasks pertaining to benefit classification, financial payer, and benefit/assignment plans.

The following diagram displays the various components of the Benefit Plan Administration functions and how **Provider Contract** fits into the process:



Provider Contracts and MITS

The primary purpose of the provider contract function is to record and maintain information about the scope of services available. Not only do provider contracts list services a provider can bill, but they also list the restrictions applicable to that service (billing rules).

Provider Contracts Panel

The billing rules are a direct reflection of OHP policy; and, unlike in OHP MMIS, authorized users can add and maintain billing rules through the graphical user interface in MITS.

Note the components in the **Provider Contract** panel below.

- 1) **Provider Contract** link
- 2) Search results list (and notice the navigation bar/icons in upper right)
- 3) Provider Contract information
- 4) **Provider Type/Specialty** panel
- 5) Medical classification search feature and tree structure

The screenshot displays the 'Provider Contract' panel in the MITS system. It is divided into several sections:

- Benefit Administration:** A menu on the left with 'Provider Contract' highlighted. Other options include Benefit Classification, Copy, Financial Payer, Form Edits, Global Restrictions, Recipient Plan, Other Insurance, Provider Contract, Reimbursement Agreement, and Rule Catalog.
- Search Results:** A table listing various contracts with columns for Financial Payer, Description, Effective Date, and Inactive Date. The table includes entries for ALCRX, ALWV, ANESC, APH, ASC, BLOC, CHSLT, CHRO, and CHOIC.
- Provider Contract Details:** A form for 'CHRO' with fields for Financial Payer (DEFAULT), Description (Chiropractor Contract), Long Description (Chiropractor Contract), Effective Date (01/01/1900), End Date (12/31/2299), and Inactive Date (12/31/2299).
- Provider Type/Specialty:** A dropdown menu for 'CHRO'.
- Directive Version:** A search area with a 'Find' button and a tree structure of medical classification codes, including Procedures, Drugs, Diagnoses, Revenue Codes, ICD-9 Procedures, and DRGs.

Provider Contract panel

Provider Contracts and OHP Policy

Provider contracts represent instructions to claims processing as a direct reflection of OHP policy. Provider contracts enable you to group services billed or performed by certain provider types/specialties, by category of service, or by a single provider. As an example, you can create provider contracts that have common or similar billing instructions and/or performing restrictions.

You can also assign billing rules to limit the services for which an enrolled provider under a contract can bill.

For example, OHP decides to have a home health contract as well as a waiver contract for nursing care services so that specific billing rules and/or services may be created for each contract. A provider who offers nursing care services may provide those services to recipients who are in a waiver program and those who are not. To receive reimbursement from both recipient populations, the provider must enroll in **both** contracts.

You can find a list of provider contracts from several sources. Here are just a few:

- MITS – Provider subsystem.
- MITS – Reference subsystem
- iTRACE – Tech Design, Reference Data Maintenance, Contract Spreadsheet.

PT/PS Assignment Panel

The **Provider Type/Specialty (PT/PS)** assignment panel is a child panel of the Provider Contract panel. On this panel, you maintain the list of valid provider type/specialty combinations for each provider contract. It is **mandatory** to assign PT/PS to a contract to make the contract available for assignment to a provider. The panel is segmented into various categories for all providers: billing providers, rendering providers, and referring providers.

The screenshot displays the "Provider Type/Specialty" assignment panel, which is organized into four main sections for different provider roles. Each section includes a list of assigned combinations, a list of available combinations, and a set of checkboxes for selection.

Section	Type/Specialties Assigned	Available Type/Specialties
Provider Type/Specialty Editing (for all providers on claim)		00/001 - 00/001 00/002 - 00/002 00/003 - 00/003 00/004 - 00/004 00/005 - 00/005
Billing Provider Type Speciality Editing	21/021 - 21/021 27/270 - 27/270 27/271 - 27/271	00/001 - 00/001 00/002 - 00/002 00/003 - 00/003 00/004 - 00/004 00/005 - 00/005
Rendering Provider Type Speciality Editing	27/270 - 27/270 27/271 - 27/271	00/001 - 00/001 00/002 - 00/002 00/003 - 00/003 00/004 - 00/004 00/005 - 00/005
Referring Provider Type Speciality Editing		00/001 - 00/001 00/002 - 00/002 00/003 - 00/003 00/004 - 00/004 00/005 - 00/005

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 services covered under Provider Contracts are grouped into sets of services or benefits; which of the following are included?

- A. Drugs
- B. Revenue Codes
- C. DRGs
- D. Diagnoses
- E. Procedures
- F. ICD-9 Procedures
- G. All of the above

A provider may be enrolled in only one provider contract.

- A. True
- B. False

It is mandatory to assign which of the following items to a provider contract for the contract to be available for assignment to a provider. Click all that apply.

- A. Provider contract name
- B. Provider contract number
- C. Description
- D. Provider type/specialty combination

Summary

In this lesson, you learned what a provider contract is, why a provider contract is important, and how provider contracts impact and affect Ohio Medicaid policy.

Maintaining Provider Contracts

What

In this topic you learn how to create a provider contract, update provider contract data, update provider contract type/specialty details, and inactivate a provider contract.

Who

Provider analysts, business analysts, configuration analysts, claims analysts, or medical policy analysts perform this task.

When

You perform this task when you are viewing/adding/updating provider contract data or researching claims within MITS.

Relevance

It is important to maintain the provider contracts so that claims are paid correctly.

Requirements

Depending on your role, you may require the following:

- A provider contract for which to search.
- A directive to add or update a provider contract.
- Provider type/specialty data to assign to the provider contract.

How To

Follow these steps from the MITS home page to maintain Provider Contracts:

Step	Action
1	Click Benefit Administration .
2	Click Provider Contract .
3	Click the Provider Contract item link.
4	Find the provider contract by following these steps:

Step	Action										
	<table border="1"> <thead> <tr> <th data-bbox="375 279 724 331">TO:</th> <th data-bbox="724 279 1373 331">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 331 724 720">Search</td> <td data-bbox="724 331 1373 720"> a. Type the provider contract name in the Code field. b. Click Search. Note: If the full contract name is not known, you can search by entering the first letter(s) that are known and the search results will display all applicable findings. Examples: If you entering: <ul style="list-style-type: none"> • "D" - search results will find DENT, DMEB, DMEOP, and DMESL. • "DE" - search results will find DENT only. </td> </tr> <tr> <td data-bbox="375 720 724 810">Select from the list</td> <td data-bbox="724 720 1373 810">Navigate the list using the page numbers and/or Next > page icon.</td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the provider contract name in the Code field. b. Click Search . Note: If the full contract name is not known, you can search by entering the first letter(s) that are known and the search results will display all applicable findings. Examples: If you entering: <ul style="list-style-type: none"> • "D" - search results will find DENT, DMEB, DMEOP, and DMESL. • "DE" - search results will find DENT only. 	Select from the list	Navigate the list using the page numbers and/or Next > page icon.				
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Select from the list	Navigate the list using the page numbers and/or Next > page icon.										
5	View the single provider contract record that displays from the search, or click the desired provider contract row from the list displayed in the Search results list.										
6	Maintain the provider contract data by following these steps: <table border="1"> <thead> <tr> <th data-bbox="375 1010 724 1062">TO:</th> <th data-bbox="724 1010 1373 1062">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1062 724 1157">Create a new provider contract</td> <td data-bbox="724 1062 1373 1157"> a. Click add. b. Enter all required information. </td> </tr> <tr> <td data-bbox="375 1157 724 1388">Update the provider type/specialty</td> <td data-bbox="724 1157 1373 1388"> a. Click the + to expand the Provider Type/Specialty panel. b. Select the appropriate type/specialty combinations from the Available Type/Specialties pick list. c. Use the (<) and (>) arrows to add types and specialties to the Type/Specialties Assigned list. </td> </tr> <tr> <td data-bbox="375 1388 724 1598">Inactivate the provider contract</td> <td data-bbox="724 1388 1373 1598"> a. Check to see if any rules exist for the provider contract. b. Click to select the provider contract. c. Type the new end date in the End Date field. d. Type the new inactive date in the Inactive Date field. </td> </tr> <tr> <td data-bbox="375 1598 724 1688">Delete a provider contract</td> <td data-bbox="724 1598 1373 1688">Contact the .net programmer.</td> </tr> </tbody> </table>	TO:	THEN:	Create a new provider contract	a. Click add . b. Enter all required information.	Update the provider type/specialty	a. Click the + to expand the Provider Type/Specialty panel. b. Select the appropriate type/specialty combinations from the Available Type/Specialties pick list. c. Use the (<) and (>) arrows to add types and specialties to the Type/Specialties Assigned list.	Inactivate the provider contract	a. Check to see if any rules exist for the provider contract. b. Click to select the provider contract. c. Type the new end date in the End Date field. d. Type the new inactive date in the Inactive Date field.	Delete a provider contract	Contact the .net programmer.
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Delete a provider contract	Contact the .net programmer.										
7	Click Save .										

Success

You have successfully completed this task when the correct provider contract data and the success validation message displays in the window.

Practice

Search for an existing Provider Contract using this information:

- Provider Contract - ALCRX
- What displays in the **Procedures Classification** drop-down list?
- What displays in the other classification drop-down lists?

Add a new provider contract using this information:

- Name - TST*** (your initials)
- Financial Payer - Default
- Description - Test Contract
- Long Description - New Provider Contract for <your name>
- Effective Date - today's date
- End Date - 12/31/2010 date
- Inactive Date - tomorrow's date

Update your provider contract using this information:

- Select the provider contract you just added
- Provider Type/Specialty - select a type/specialty combination

Summary

In this topic you learned how to create a provider contract, update provider contract data, update provider contract type/specialty details, and inactivate a provider contract.

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.

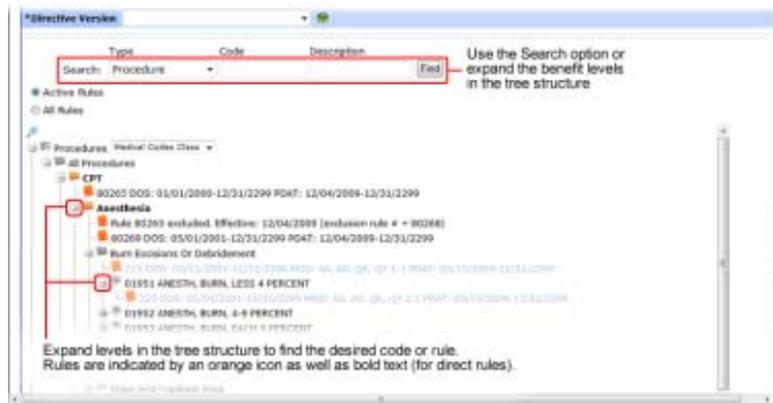
Another rule you might consider is for Other Insurance (OI), also referred to as Third Party Liability. The OI plan includes a list of services covered by the other carriers. OI plans might also cover services that the State Healthcare program covers. During the adjudication process, MITS compares service 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:

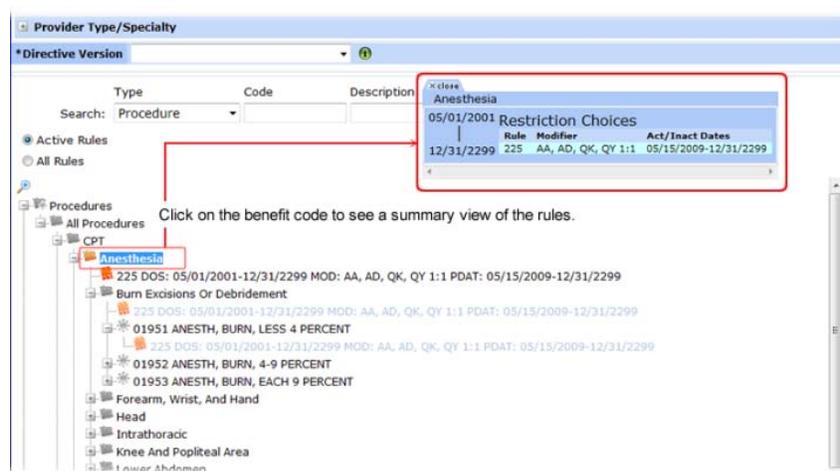
Benefit Type	Code Type and Source of the information
Procedures	CPT (American Medical Association) HCPCS (The Medical Management Institute)
Drugs	Generic Therapeutic Class Specific Therapeutic Class HIC4 GCN NDC
Diagnoses	CDC (Centers for Disease Control)

Benefit Type	Code Type and Source of the information
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.



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.

- True
- False

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

- Reimbursement Agreement rule
- Provider Contract rule
- Other Insurance rule
- Recipient Plan rule

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

- Inherited rule
- Waterfall rule
- Optional 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 provider contract rules in the Reference subsystem:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Provider Contract .						
4	Click the Provider Contract submenu group.						
5	Select the provider contract with these instructions: <table border="1" data-bbox="371 783 1375 1167"> <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:						
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6	Find the benefit code in the medical classification with these instructions: <table border="1" data-bbox="371 1272 1375 1707"> <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.						

Step	Action
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

Practice searching for a **provider contract rule** using the following information:

Practice 1:

- Benefit Group: Provider Contract
- Type: AMBLC (Ambulance)
- Code: A0040

Record the rule number _____.

Be prepared to discuss the parameters for this rule.

Practice 2:

Practice searching for a rule using the following information:

- Benefit Group: Provider Contract
- Type: PHYS (Physician)
- Code: 99211

Record the rule number(s) _____.

Be prepared to discuss the parameters for this rule.

Optional practices:

Practice viewing rules and the tree structure using this information:

- Benefit Group: Provider Contract>CHIRO
- Procedure code 72010
- Look at the Rule Summary view
- View the rule 147 rule edit panel
- View rules 147, 149, and 150 are direct at the Radiology level in the tree

Answer some questions about the rules you have just seen:

- What are the age restrictions on the different rules?
- Why are there 3 different rule 147s; what is the difference?
- Which rules are direct at the Radiology level in the tree
- Which rules are under the Medicine level in the tree?- different rules - 148, 151, 152

Learning points:

- Navigating the tree structure
- Using the search functionality
- Rule Summary view
- View rule edit panels
- Direct and inherited rules

Summary

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

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:

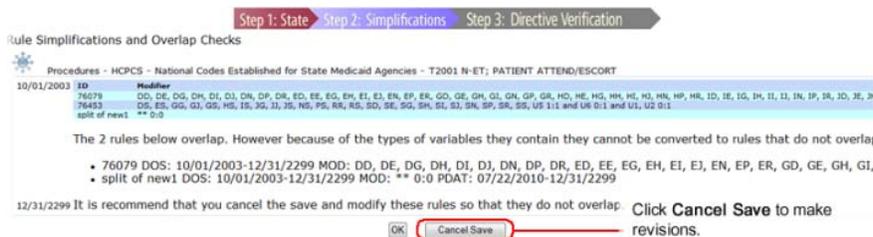
To proceed through the three-step save process, click **OK** on each window to continue. You can cancel the save at any point that the system finds a conflict, if desired.





Conflicts

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



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		

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

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

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

Summary

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

Creating and Saving Rules

What

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

The steps for adding rules are similar for recipient plans, provider contracts, and reimbursement agreements; however, the variables within the rule panels may differ.

Who

A configuration analyst performs this task.

When

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

Relevance

You must create rules to define and manage the policies for processing and paying claims. A benefit is not covered unless it has a rule to cover it. The order in which you create the rules is critical. Your goal is to minimize the number of conflicts during data entry. Create group level rules **first**, and then create any detail level rules.

Requirements

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

Guidelines

Each rule can be configured to include, exclude, or bypass parameters when defining 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, just to name a few.

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 add provider contract rules in the Reference subsystem:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Provider Contract .						
4	Click Provider Contract under "Select area to add or modify below".						
5	Select the provider contract with these instructions: <table border="1" data-bbox="371 783 1375 1167"> <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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6	Find the level where you want to add a rule by following these steps: <table border="1" data-bbox="371 1272 1375 1614"> <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.
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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.						
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.						

Step	Action
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 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 the confirmation window displays stating that the save was successful.

Practice

Practice creating a **provider contract rule** using this information:

Scenario 1:

- Provider Contract- TST***
- Procedures - (Standard)
- Navigate to a procedure under All Procedures>HCPCS>Administrative, Miscellaneous and Investigational level
- Directive version - CNV2009
- Age - 0 - 21
- Place of Service Editing - Include - 04 Homeless Shelter

Optional Scenario 2:

- Provider Contract- NFC (Nursing Facility)
Search for procedure code H0002
- Each person can take one procedure code starting with H0002 (to avoid duplication)
- Directive version - CNV2009
- Billing PT/PS - 68/680
- Hint: You will need to click Yes to open the Provider Type/Specialty editing portion
- Require Prior Authorization

- Cancel the rule instead of saving it.

Does your rule make it through the 3-step save process?

When you are finished, view your rule in the rule edit panel and also the rule summary.

Summary

In this topic you learned how to create new rules in MITS.

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).

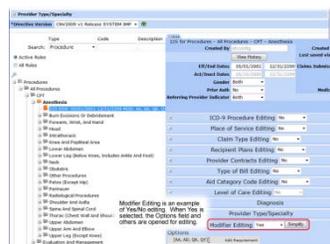
Field options include edits for the following:

- 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:



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.
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:

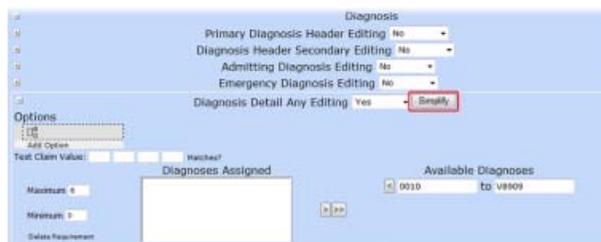
Provider Type/Specialty Assigned	Description
Billing Provider	Provider billing for the service.
Performing Provider	Provider performing the service.
Referring Provider	Provider referring a specialist.

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.



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 a software interface titled "Diagnosis Detail Any Editing". At the top right, there are "Yes" and "Simplify" buttons. The main area is divided into several sections:

- Options:** Contains a text box with "[502-700]", an "Add Option" button, and an "Add Requirement" button (highlighted with a red box).
- Test Claim Values:** A row of four empty input fields.
- Diagnoses Assigned:** A central box containing the text "502 - 700".
- Available Diagnoses:** A list of three items: "0000 to 500", "501 to 501", and "7000 to 9999".
- Fields:** "Maximum" is set to "4" (highlighted with a red box), and "Minimum" is set to "0".
- Buttons:** "Delete Requirement" is at the bottom left, and an "OR" button is between the "Diagnoses Assigned" and "Available Diagnoses" sections.

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. Yes/No
- B. Include/Exclude
- C. Multiple Choice
- 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. Check
- B. Validate
- 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 provider contract rules in the Reference subsystem via the hierarchical tree structure:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Provider Contract .
4	Click Provider Contract under the submenu area.

Step	Action						
5	<p>Select the provider contract with these instructions:</p> <table border="1" data-bbox="375 363 1377 741"> <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="375 415 727 604">Search</td> <td data-bbox="727 415 1377 604"> 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 data-bbox="375 604 727 741">Navigate the search results list</td> <td data-bbox="727 604 1377 741"> 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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6	<p>To search for the level where you want to add a rule, follow these steps:</p> <table border="1" data-bbox="375 852 1377 1192"> <thead> <tr> <th data-bbox="375 852 727 905">TO:</th> <th data-bbox="727 852 1377 905">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 905 727 1052">Search</td> <td data-bbox="727 905 1377 1052"> 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 1052 727 1192">Navigate the tree</td> <td data-bbox="727 1052 1377 1192"> 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.						
7	Click to expand rule criteria and review before making changes according to policy/directive.						
8	Select a directive from the Directive Version drop-down list.						
9	For a direct rule, click to expand the rule criteria. For an inherited rule, right click the rule and select Modify Rule (Excl/New) .						
10	Expand the desired area, and make the applicable changes in the rule.						
11	Click Close . Note: If it was an inherited rule, both the excluded rule and new rule displays.						
12	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.						

Step	Action
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"> 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 an existing **provider contract rule** using this information:

- Provider Contract - TSTXXX
- Click the rule that you just created in the Creating and Saving Rules lesson
- Reminder: Navigate to All Procedures>HCPCS>Administrative, Miscellaneous and Investigational level
- Add a Billing Provider Type Specialty editing to the rule (79/791)

Summary

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

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

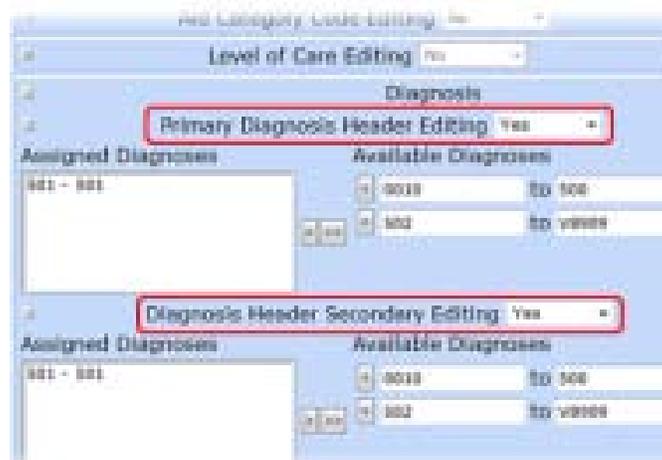
You can perform diagnosis editing in recipient plans, provider contracts, reimbursement agreements, and global restrictions. Diagnosis editing options vary by benefit type; for example, Procedure to Diagnosis. The procedure requires one of the specified diagnoses to be a match.

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.

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. Available Diagnoses
- B. Test Claim Value
- C. Simplify
- 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 provider contract rule:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Provider Contract .

Step	Action						
4	<p>Select the provider contract with these instructions:</p> <table border="1" data-bbox="375 363 1377 741"> <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="375 415 727 604">Search</td> <td data-bbox="727 415 1377 604"> 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 data-bbox="375 604 727 741">Navigate the search results list</td> <td data-bbox="727 604 1377 741"> 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.						
9	<p>Click the Diagnosis Editing drop-down list and select Yes next to the desired selection.</p> <p>Note: Additional options may be applied to the Coverage Rule display.</p>						

Step	Action														
10	<p>Configure the Diagnosis Editing by following these steps:</p> <table border="1" data-bbox="375 363 1377 1787"> <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="375 415 727 594">Add/split a diagnosis range</td> <td data-bbox="727 415 1377 594"> <ol style="list-style-type: none"> Click the To field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Press the Enter key. Continue splitting the ranges as necessary. </td> </tr> <tr> <td data-bbox="375 594 727 800">Create a single diagnosis segment</td> <td data-bbox="727 594 1377 800"> <ol style="list-style-type: none"> Click the To field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Type the single diagnosis in both the From and To fields. Click outside the To field. </td> </tr> <tr> <td data-bbox="375 800 727 1129">Modify the current option where applicable</td> <td data-bbox="727 800 1377 1129"> <ol style="list-style-type: none"> Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. Click the To diagnosis field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Press Enter. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. </td> </tr> <tr> <td data-bbox="375 1129 727 1549">Add diagnoses to the header Editing Rule</td> <td data-bbox="727 1129 1377 1549"> <ol style="list-style-type: none"> Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. Click the To diagnosis field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Press Enter. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. 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 1549 727 1755">Remove diagnoses from the Assigned list</td> <td data-bbox="727 1549 1377 1755"> <ol style="list-style-type: none"> Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. Click the single right (>) Assigned Diagnoses range to move the desired range to the Available Diagnoses list. </td> </tr> <tr> <td data-bbox="375 1755 727 1787">Add multiple</td> <td data-bbox="727 1755 1377 1787"> <ol style="list-style-type: none"> Click the current default option (the gray box </td> </tr> </tbody> </table>	TO:	THEN:	Add/split a diagnosis range	<ol style="list-style-type: none"> Click the To field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Press the Enter key. Continue splitting the ranges as necessary. 	Create a single diagnosis segment	<ol style="list-style-type: none"> Click the To field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Type the single diagnosis in both the From and To fields. Click outside the To field. 	Modify the current option where applicable	<ol style="list-style-type: none"> Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. Click the To diagnosis field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Press Enter. 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	<ol style="list-style-type: none"> Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. Click the To diagnosis field. Enter a valid diagnosis code that falls within the range of the original From and To fields. Press Enter. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. 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	<ol style="list-style-type: none"> Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. Click the single right (>) Assigned Diagnoses range to move the desired range to the Available Diagnoses list. 	Add multiple	<ol style="list-style-type: none"> Click the current default option (the gray box
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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	<p>If the system finds a conflict:</p> <p>a. Click Cancel Save.</p> <p>b. Make the appropriate changes to the rule to resolve the conflict.</p> <p>c. Click Save (again).</p>				

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 provider contract using this information:

- Provider Contract - TST*** (the one you created)
- 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.

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

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.

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

Add Requirement

Add Option

Test Claim Value: Matches?

Inclusive

Maximum

Minimum

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. White Test Claim Value boxes
- B. Available Modifiers box
- C. Inclusive checkbox
- 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 home page to configure a provider contract rule with modifier editing:

Step	Action
1	Click Reference .
2	Click Benefit Administration .

Step	Action						
3	Click Provider Contract .						
4	Select the provider contract with these instructions: <table border="1" data-bbox="375 426 1377 810" style="margin-left: 40px;"> <thead> <tr> <th data-bbox="375 426 727 478">TO:</th> <th data-bbox="727 426 1377 478">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 478 727 667">Search</td> <td data-bbox="727 478 1377 667"> 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 data-bbox="375 667 727 810">Navigate the search results list</td> <td data-bbox="727 667 1377 810"> 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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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.						
9	Click the Options (gray area) to start the editing.						

Step	Action												
10	<p>Configure Modifier Options by following these steps:</p> <table border="1" data-bbox="375 363 1377 1814"> <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="375 415 727 558">Add assigned modifier codes</td> <td data-bbox="727 415 1377 558"> <ol style="list-style-type: none"> Click to select the combination of Modifier code(s) from the Available Modifiers pick list. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box. </td> </tr> <tr> <td data-bbox="375 558 727 947">Modify the current option</td> <td data-bbox="727 558 1377 947"> <ol style="list-style-type: none"> Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list. </td> </tr> <tr> <td data-bbox="375 947 727 1152">Disallow any modifier codes on claim</td> <td data-bbox="727 947 1377 1152"> <ol style="list-style-type: none"> Ensure the Inclusive checkbox is checked. Select the first available modifier option ** - Audit Default Modifier. 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 1152 727 1482">Add modifier requirements (AND condition)</td> <td data-bbox="727 1152 1377 1482"> <ol style="list-style-type: none"> Click Add Requirement. Click the area with the dotted line after and. Click the desired modifiers in the Available list. Click the left (<) to move them to the Assigned pick list. Click to select (or deselect) the Inclusive checkbox. 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 1482 727 1814">Add modifier option (OR condition)</td> <td data-bbox="727 1482 1377 1814"> <ol style="list-style-type: none"> Click Add Option. Click the brackets inside the dotted line box. Click to select the desired modifiers in the Available list. Click the left (<) to move them to the Assigned list. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. Type the minimum number of Modifier codes allowed (1-4) in the Minimum field. </td> </tr> </tbody> </table>	TO:	THEN:	Add assigned modifier codes	<ol style="list-style-type: none"> Click to select the combination of Modifier code(s) from the Available Modifiers pick list. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box. 	Modify the current option	<ol style="list-style-type: none"> Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list. 	Disallow any modifier codes on claim	<ol style="list-style-type: none"> Ensure the Inclusive checkbox is checked. Select the first available modifier option ** - Audit Default Modifier. 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)	<ol style="list-style-type: none"> Click Add Requirement. Click the area with the dotted line after and. Click the desired modifiers in the Available list. Click the left (<) to move them to the Assigned pick list. Click to select (or deselect) the Inclusive checkbox. 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)	<ol style="list-style-type: none"> Click Add Option. Click the brackets inside the dotted line box. Click to select the desired modifiers in the Available list. Click the left (<) to move them to the Assigned list. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. Type the minimum number of Modifier codes allowed (1-4) in the Minimum field.
TO:	THEN:												
Add assigned modifier codes	<ol style="list-style-type: none"> Click to select the combination of Modifier code(s) from the Available Modifiers pick list. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box. 												
Modify the current option	<ol style="list-style-type: none"> Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list. 												
Disallow any modifier codes on claim	<ol style="list-style-type: none"> Ensure the Inclusive checkbox is checked. Select the first available modifier option ** - Audit Default Modifier. 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)	<ol style="list-style-type: none"> Click Add Requirement. Click the area with the dotted line after and. Click the desired modifiers in the Available list. Click the left (<) to move them to the Assigned pick list. Click to select (or deselect) the Inclusive checkbox. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0). 												
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11	<p>Additional modifier options by following these steps:</p> <table border="1" data-bbox="375 285 1377 909"> <thead> <tr> <th data-bbox="375 285 727 338">TO:</th> <th data-bbox="727 285 1377 338">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 338 727 600">Simplify</td> <td data-bbox="727 338 1377 600"> 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="375 600 727 909">Test Claim Matches</td> <td data-bbox="727 600 1377 909"> 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 **provider contract rule** with modifier editing using the following information and the same rule you used in last practice:

- Provider Contract - TST*** (the one you created)
- Use the same procedure code you used in the previous lesson
- 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.

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:

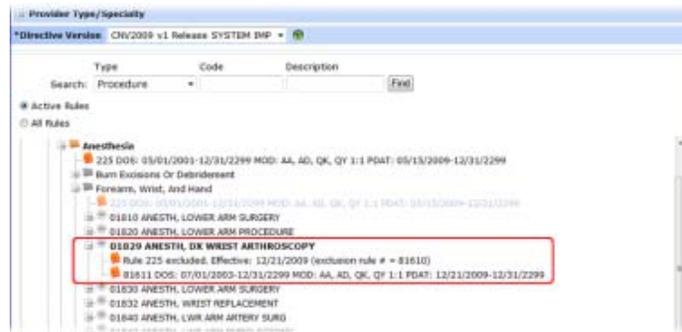
- The rule is a **direct** rule at the highest level that it applies.
- The rule is an **inherited** rule on codes that fall beneath the top level.

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.



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:

- Deletes the inherited rule from a benefit in a subgroup/folder.
- Changes the inherited rule to an exclude status and adds a new rule in the same benefit/group level.
- 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 provider contract rules:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Provider Contract .

Step	Action								
4	<p>Select the provider contract with these instructions:</p> <table border="1" data-bbox="375 363 1377 741"> <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="375 415 727 604">Search</td> <td data-bbox="727 415 1377 604"> 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 data-bbox="375 604 727 741">Navigate the search results list</td> <td data-bbox="727 604 1377 741"> 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	<p>To search for the level where you want to find a rule, follow these steps:</p> <table border="1" data-bbox="375 846 1377 1192"> <thead> <tr> <th data-bbox="375 846 727 898">TO:</th> <th data-bbox="727 846 1377 898">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 898 727 1056">Search</td> <td data-bbox="727 898 1377 1056"> 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 1056 727 1192">Navigate the tree</td> <td data-bbox="727 1056 1377 1192"> 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	<p>Remove a rule based on the type of rule by following these steps:</p> <table border="1" data-bbox="375 1455 1377 1810"> <thead> <tr> <th data-bbox="375 1455 727 1507">TO:</th> <th data-bbox="727 1455 1377 1507">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1507 727 1570">Remove a direct rule</td> <td data-bbox="727 1507 1377 1570">Right click the rule and select Inactivate.</td> </tr> <tr> <td data-bbox="375 1570 727 1654">Remove an inherited rule</td> <td data-bbox="727 1570 1377 1654">Right click the rule and select Exclude Rule.</td> </tr> <tr> <td data-bbox="375 1654 727 1810">Remove an inherited rule, but add a new rule in its place</td> <td data-bbox="727 1654 1377 1810">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> </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.
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.								

Step	Action		
	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; padding: 5px;">Remove a rule before saving it</td> <td style="width: 50%; padding: 5px;">Click Cancel.</td> </tr> </table>	Remove a rule before saving it	Click Cancel .
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	<p><u>If the save is successful</u>, click OK to dismiss the confirmation window.</p>		
11	<p>If the system finds a conflict:</p> <ol style="list-style-type: none"> a. Click Cancel Save b. Make the appropriate changes to the rule to resolve the conflict. c. 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 **provider contract rule** using this information:

- Reference>Benefit Administration>Provider Contract
- Use same procedure level you created before
- Inactivate the rule you created at the HCPCS 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.

Introduction to Conflict Report Errors

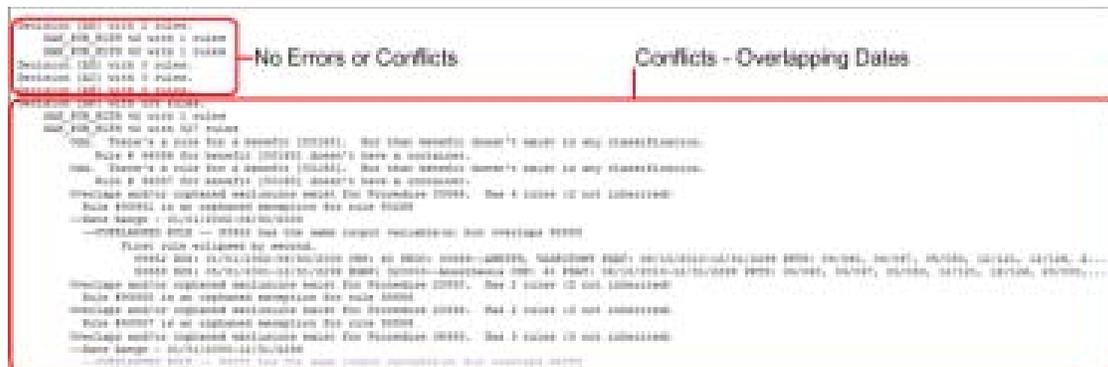
Overview

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:



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

1st letter	Description	2nd letter	Description
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:

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

SAK	PK	FIN	CDE	POL/DSC	POL/DSC	POL/DSC	TYPRID	RECIID	MAJ/NO	STAN/NO	CT	E/NO	COP/NO	DUAL/NO	TP	HUM	HEFH/AM	HELO/TE	EFFE		
1	1	TALL	All Benefit	All Benefit	ENFT	N													0	19900101	
1	1	1MCAID	Medicaid	Full medic	ENFT	N													0	19900101	
4	4	1MTR	Medicaid	Medicaid	ENFT	N													0	19900101	
5	3	1DMA	Disability	Disability	ENFT	N													0	19900101	
6	4	1DRSV	Disability	Disability	ENFT	N													0	19900101	
7	6	1CHOC	Choices	Choices	ENFT	N													0	20011101	
8	9	1ASL	Assisted L	Ohio Dept	ENFT	N													0	20060701	
9	10	1ALEN	Emergency	Emergency	ENFT	N													0	19900101	
10	11	1ALCRX	ODADAS	ODADAS	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	10	0	19900101
11	12	1AIDS	Aids Waiv	Aids Waiv	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	12	0	19880101
12	13	1VIT50	Model 50	Model 50	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	13	0	19960917
13	14	1VENT	Ventilator	Ventilator	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	14	0	19891215
14	15	1TRCO	Transitions	Transitions	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	15	0	20060701
15	16	1TRSD	Transitions	Transitions	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	16	0	20020101
16	17	1SLMB	Special Le	Special Le	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	17	0	19900101
17	18	1RES14	Residentia	Residentia	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	18	0	19900101
18	19	1RES	Residentia	Residentia	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	19	0	19900101
19	20	1REF	Refugee	Refugee	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	20	0	19900101
20	21	1QWD	Qualified	Qualified	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	21	0	19900101
21	22	1QMB	Qualified	Qualified	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	22	0	19900101
22	23	1QI1	QI 1/QI 2	Special Le	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	23	0	19900101
23	24	1PASSP	Passport	Passport	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	24	0	19900101
24	25	1PAS14	Passport	Passport	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	25	0	19900101
25	26	1PACE	Pace	Pace	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	26	0	19960930
26	27	1OONC	Old Ohio	Old Ohio	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	27	0	19900101
27	28	1OMH	Ohio Ment	Ohio Ment	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	28	0	19900101
28	29	1OHC	Ohio Home	Ohio Home	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	29	0	20060701
29	30	1OBR	Ohio Wav	Ohio Wav	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	30	0	19900101
30	31	1MSP	Medicaid	Medicaid	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	31	0	20050701
31	32	1MRLV1	MR Level	MR Level	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	32	0	20021201
32	33	1MRIO	MR IO	MR IO	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	33	0	19910301
33	34	1MOD50	Model 50	Model 50	ENFT	N	N	N	N	N	N	N	N	N	N	N	N	N	34	0	19831001
34	35	1MCARD	HRD	ASE/HRD	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	1	19900101
35	36	1KTRNA	Katrina Wv	Katrina Wv	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	2	20050901
36	37	1HOSPC	Hospice	Hospice	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	3	19900101
37	38	1CDPHV	County On	County On	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	4	19900101
38	39	1CDPHR	County On	County On	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	5	19900101
39	40	1PACTP	PACT Phy	PACT Phy	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	6	19900101
40	41	1PACID	PACT Phy	PACT Phy	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	7	19900101
41	42	1PACEA	PACE	PACE	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	0	8	19900101

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. Decision [PP] - P for provider and P for procedure.
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 RESPNS 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 - NONEEMERG TRANSP MILEAGE which isn't in this classification
SAK_PROV_PGM 29 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. Prov_Pgm 50 - Therapy Contract
----Classification sak is 144 -----
3. The rule points to the level in the medical classification where the rule is found.
Rule Sak# 82211 has BGRP=314547, but this group does not exist.
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.

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.

Reports

Listed below are the most commonly-used reports for conflict report errors:

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.

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="375 1140 1377 1583"> <thead> <tr> <th data-bbox="375 1140 727 1192">TO:</th> <th data-bbox="727 1140 1377 1192">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1192 727 1444">Search</td> <td data-bbox="727 1192 1377 1444"> <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="375 1444 727 1583">Navigate the search results list</td> <td data-bbox="727 1444 1377 1583"> <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 705"> <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="375 562 727 705">Navigate the tree</td> <td data-bbox="727 562 1377 705"> 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 1010 1377 1629"> <thead> <tr> <th data-bbox="375 1010 727 1062">IF:</th> <th data-bbox="727 1010 1377 1062">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1062 727 1188">A direct rule is incorrect and needs to be modified</td> <td data-bbox="727 1062 1377 1188"> c. Left click the direct rule. d. Modify the rule edit panel as appropriate </td> </tr> <tr> <td data-bbox="375 1188 727 1314">An inherited rule is incorrect only and needs to be modified</td> <td data-bbox="727 1188 1377 1314"> e. Right click the rule. f. Select Modify Rule (excl/new). g. Edit the new rule panel. </td> </tr> <tr> <td data-bbox="375 1314 727 1440">A direct rule is incorrect and needs to be removed</td> <td data-bbox="727 1314 1377 1440"> h. Right click the rule. i. Select Inactivate. </td> </tr> <tr> <td data-bbox="375 1440 727 1566">An inherited rule is incorrect only and needs to be removed</td> <td data-bbox="727 1440 1377 1566"> j. Right click the rule. k. Select Exclude. </td> </tr> <tr> <td data-bbox="375 1566 727 1629">A new rule is required</td> <td data-bbox="727 1566 1377 1629"> l. Right click the benefit level m. Select Add rule. </td> </tr> </tbody> </table>	IF:	THEN:	A direct rule is incorrect and needs to be modified	c. Left click the direct rule. d. Modify the rule edit panel as appropriate	An inherited rule is incorrect only and needs to be modified	e. Right click the rule. f. Select Modify Rule (excl/new) . g. Edit the new rule panel.	A direct rule is incorrect and needs to be removed	h. Right click the rule. i. Select Inactivate .	An inherited rule is incorrect only and needs to be removed	j. Right click the rule. k. Select Exclude .	A new rule is required	l. Right click the benefit level m. Select Add rule .
IF:	THEN:												
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A new rule is required	l. Right click the benefit level m. 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	<u>If the save is successful</u> , 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.

Introduction to Provider Contract Group Types

Overview

This lesson introduces you to provider contract group types.



Provider Contract Group Type and MITS

Provider contract group types provide a way to group provider contracts together to apply common billing criteria. This allows the provider contracts to be classified for specific types of use.

For example: You may group Health Maintenance Organization (HMO) provider contracts into a Managed Care Organization (MCO) group type. MITS expects this type of service to be billed as an encounter. In this situation, criteria or parameters are set for the provider contract group rather than individual contracts. This allows the claims engine code to reference table data at a group level rather than an individual level.

The purpose of the **Provider Contract Group Type** panel is to add and update provider contract group types. It is also used to add and update provider contracts to an associated group type.

The screenshot displays the 'Provider Contract Group Type' application. At the top, a list of group types is shown: 1. FFS PC (NOT USED), 2. MCO (MANAGED CARE), 3. MANAGED CARE, 4. FFS (NOT USED), and 5. INFORMATIONAL. The '3. MANAGED CARE' option is selected and highlighted. Below this, the 'Provider Contract Group Type' dropdown is set to '3'. The description is 'MANAGED CARE' and the long description is 'PROVIDER CONTRACT GROUP FOR MANAGED CARE PLANS OR CAPITATED PLANS.'. Below this, a table shows the selected provider contract details:

Provider Contract	Effective Date	End Date
MNCIP	03/08/2010	12/31/2299

In the example, the group type is Managed Care Provider Contract Group Type. Note the type (3) and description (Managed Care).

Provider Contract Group Type and OHP Policy

Provider Contract Group Types allow you to classify provider contracts for specific types of use. Currently, OHP uses only the MCO (Managed Care Organization) group type. The solution for managed care (recipient) assignment plans includes maintaining the rules in the provider contract. The rules specify the services covered under the MCO agreement. When a provider submits a Fee for Service (FFS) claim, MITS reviews the recipient's coverage and then determines if the service is covered under the provider's MCO contract. If the service billed is included in the provider's MCO contract, then MITS denies the FFS claim.

The advantage of moving the rules to the provider contracts is to reduce the number of assignment plans needed, which reduces the complexity of the enrollment logic for managed care. By creating a single MCO assignment, the services covered by the individual HMO are maintained on the MCO provider contract(s), allowing the recipient to be enrolled under a single assignment.

The following is an illustration of how recipient assignment plans, rules in the provider contracts, and criteria for the MCO provider contract group type work together:

- A provider submits a claim for a recipient who is assigned to an MCO assignment plan.
- Upon receipt of the claim, MITS verifies if the provider is set up under a provider contract, which has been assigned to an MCO provider contract group type.
- MITS then determines if the provider is enrolled in an MCO contract, which has been set up under the MCO provider contract group type.
- Based on the MCO group type of the provider contract, MITS processes the claim according to contract rules (pay or deny depending upon the claim type - encounter vs. FFS).

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.

Provider contract group types provide a way to group provider contracts together for what purpose?

- A. To apply common billing criteria.
- B. To create more work for the staff.
- C. To group all providers in the same city together.
- D. To ensure the providers all bill the same rates for the same procedures.

MITS allows you to add a provider contract to an existing group type.

- A. True
- B. False

Summary

In this topic, you learned how provider contract group types provide a way to group provider contracts together so that common billing criteria can be created for them in the claims engine. This will allow the provider contracts to be classified for specific types of use.

Maintaining Provider Contract Groups

What

In this topic you learn how to add, update, and delete provider contract group types.

Who

A provider relations analyst, claims analyst, medical policy analyst, business analyst, Configuration analyst, or other OHP staff roles perform this task.

When

Perform this task when researching claims or maintaining provider contracts, as needed.

Relevance

Maintaining provider contract groups helps us to apply common billing criteria.

Requirements

Depending on your role, you may require the following:

- A provider contract group for which to search.
- A directive to add or update a provider contract group.
- An end date and description for the provider contract.

How To

Follow these steps from the MITS home page to search for, add, delete, and update a provider contract group:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Provider Contract .
4	Click Provider Contract Group Type .
6	Maintain the Provider Contract Group Types by following these steps:

Step	Action												
	<table border="1"> <thead> <tr> <th data-bbox="375 321 727 373">TO:</th> <th data-bbox="727 321 1373 373">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 373 727 520">Add a group type</td> <td data-bbox="727 373 1373 520"> a. Click add. b. Type a brief description in the Description field. c. Type a detailed description in the Long Description field. </td> </tr> <tr> <td data-bbox="375 520 727 667">Delete a group type</td> <td data-bbox="727 520 1373 667"> a. Click to select the provider contract group type from the list. b. Click delete. c. Click OK. </td> </tr> <tr> <td data-bbox="375 667 727 1031">Add a provider contract to a group type</td> <td data-bbox="727 667 1373 1031"> a. Click to select the provider contract group type from the list. b. Select a provider contract by either method: <ul style="list-style-type: none"> o <u>If known</u>, type the provider contract in the Provider Contract field. o <u>If not know</u>, click Search. c. Click add. d. Select the desired provider contract to update. e. If necessary, modify the values in the Effective Date field and/or End Date field (defaults to 12/31/2299). </td> </tr> <tr> <td data-bbox="375 1031 727 1367">Delete a provider contract from a group type</td> <td data-bbox="727 1031 1373 1367"> a. Click to select the provider contract group type from the list. b. Select a provider contract from the groups listed below by either method: <ul style="list-style-type: none"> o <u>If known</u>, type the provider contract in the Provider Contract field. o <u>If not known</u>, click Search. c. Select the desired provider contract to delete. d. Click delete. e. Click OK. </td> </tr> <tr> <td data-bbox="375 1367 727 1541">Update a provider end date</td> <td data-bbox="727 1367 1373 1541"> a. Click the desired type of provider contract from the Provider Contract Group Type list. b. Click to select the desired group row. c. Type the new end date in the End Date field. d. Click OK. </td> </tr> </tbody> </table>	TO:	THEN:	Add a group type	a. Click add . b. Type a brief description in the Description field. c. Type a detailed description in the Long Description field.	Delete a group type	a. Click to select the provider contract group type from the list. b. Click delete . c. Click OK .	Add a provider contract to a group type	a. Click to select the provider contract group type from the list. b. Select a provider contract by either method: <ul style="list-style-type: none"> o <u>If known</u>, type the provider contract in the Provider Contract field. o <u>If not know</u>, click Search. c. Click add . d. Select the desired provider contract to update. e. If necessary, modify the values in the Effective Date field and/or End Date field (defaults to 12/31/2299).	Delete a provider contract from a group type	a. Click to select the provider contract group type from the list. b. Select a provider contract from the groups listed below by either method: <ul style="list-style-type: none"> o <u>If known</u>, type the provider contract in the Provider Contract field. o <u>If not known</u>, click Search. c. Select the desired provider contract to delete. d. Click delete . e. Click OK .	Update a provider end date	a. Click the desired type of provider contract from the Provider Contract Group Type list. b. Click to select the desired group row. c. Type the new end date in the End Date field. d. Click OK .
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Add a group type	a. Click add . b. Type a brief description in the Description field. c. Type a detailed description in the Long Description field.												
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Update a provider end date	a. Click the desired type of provider contract from the Provider Contract Group Type list. b. Click to select the desired group row. c. Type the new end date in the End Date field. d. Click OK .												
7	Click Save .												

Success

You have successfully completed this task when the correct provider contract group information displays.

Practice

Practice adding a provider contract group type

- For the **Description**, type **Test - <your name>**
- For the **Long Description**, type **Test - <your name>**
- Add the ANES provider contract to your new group type.

Summary

In this topic, you learned how to search, add, update, and delete provider contract groups.

Introduction to Provider Contract / Claim Type

Overview

In this lesson you will learn about the provider contract/claim type combinations and their significance to MITS and OHP policy.



Provider Contract/Claim Type and MITS

A provider contract claim type provides a way to restrict provider contracts to one or more specific claim types. Sometimes called a "crosswalk" or an "algorithm," it is a list of the valid claim types that each of the provider contracts are allowed to bill.

For example: Post a restriction that a chiropractor provider contract can only submit claims as a straight Medicaid claim on a CMS-1500 claim form (claim type M) and/or on as a Medicare crossover on a CMS-1500 claim form (claim type B).

Provider Contract/Claim Type and OHP Policy

If OHP policy mandates restrictions of a provider contract to one or more specific claim types, authorized users must establish the allowable claim type(s) in the cross reference

table using the **Provider Contract/Claim Type** panel. If a provider contract is not associated to a claim type in this cross reference table, MITS cannot process the claim.

Rule-based claim type editing is **not** performed from the Provider Contract/Claim Type panel. Rule-based claim type restrictions are indicated on the Provider Contract Rule Panel for the desired services.

For example: The Provider Contract/Claim Type entry shown here is used to set **claim type M (CMS-1500 claims)** for the Dental Provider Contract. There is also a rule for the Dental Provider Contract under the procedure level for Head (#12584) which shows the claim type restriction highlighted with the red outline (**CT:M**). The Provider Contract Rule Panel is used to create the desired rule.

The screenshot displays two panels from a software interface. The top panel, titled "Provider Contract/Claim Type", shows a table with columns for Provider Contract, Claim Type, Effective Date, and End Date. The table lists various provider contracts (ASC, CHRO, CHOC, CLNC, CMH, DENT) and their associated claim types (CMS 1500 CLAIMS, CMS 1500 XOVER CLAIMS). The entry for "DENT" with "CMS 1500 CLAIMS" is highlighted. Below the table, there is a search area where "Provider Contract" is set to "DENT" and "Claim Type" is set to "M - CMS 1500 CLAIMS". The "Effective Date" is "01/01/1900" and the "End Date" is "12/31/2299".

The bottom panel, titled "Directive Version", shows a search area with "Type" set to "Procedure" and "Code" set to "12584". The "Description" field contains "MOD: AA, QK, QY 1:1 PDAT: 07/02/2009-12/31/2299". Below the search area, there are radio buttons for "Active Rules" and "All Rules". Under "Active Rules", there is a tree view showing a "Head" category with a sub-entry "12584 DOS: 05/01/2001-12/31/2299 CT: M" highlighted with a red box. Below this, there are several other entries under "Head": "00120 ANESTH, EAR SURGERY", "00144 ANESTH, CORNEAL TRANSPLANT", and "00145 ANESTH, VITREORETINAL SURG".

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.

With the Provider Contract/Claim Type panel, you can stipulate a restriction that a chiropractor provider contract can only submit claims as a straight Medicaid claim on a CMS-1500 claim form (claim type M) and/or on as a Medicare crossover on a CMS-1500 claim form (claim type B).

- A. True
- B. False

Provider Contract/Claim Type table is also referred to as a _____.

- A. Pyramid
- B. Multiple
- C. Crosswalk

If a provider contract is not associated to a claim type in the **Provider Contract/Claim Type** cross reference table, the claim can still be processed.

- A. True
- B. False

Summary

In this lesson, you learned about how the Provider Contract/Claim Type panel provides a way to restrict provider contracts to one or more specific claim types. Sometimes called a "crosswalk," it is a list of the valid claim types that each provider contract is allowed to bill.

Maintaining Provider Contract Claim Types

What

In this topic you learn how to add, update, and delete combinations of provider contracts and claim types.

Who

A configuration analyst performs this task.

When

A performer may do this task when researching provider contract data, claims, and policy data.

Relevance

The **Provider Contract/Claim Type** panel provides a way to restrict provider contracts to one or more specific claim types.

Requirements

You need a valid provider contract and claim type combination.

How To

To maintain the Provider Contract/Claim Type panel, perform the following steps:

Step	Action								
1	Click Reference .								
2	Click Benefit Administration .								
3	Click Provider Contract .								
4	Click Provider Contract/Claim Type .								
5	<p>Maintain the provider contract/claim types by performing the following steps:</p> <table border="1"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Add a claim type to an existing provider contract</td> <td> <ol style="list-style-type: none"> Click add. Type the provider contract code in the Provider Contract field. Click Search. Select the provider contract from the search results list. Select the appropriate claim type from the Claim Type drop-down list. Enter an Effective date for the provider contract/claim type association. Enter an End date for the provider contract/claim type association. </td> </tr> <tr> <td>Update the end date to an existing provider contract/claim type</td> <td> <ol style="list-style-type: none"> Click to select and view the desired provider contract/claim type crosswalk. Type a new end date in the *End Date field. </td> </tr> <tr> <td>Delete an association of a claim type from its existing provider contract</td> <td> <ol style="list-style-type: none"> Click to select and view the desired provider contract/claim type crosswalk. Click delete. Click OK. </td> </tr> </tbody> </table>	TO:	THEN:	Add a claim type to an existing provider contract	<ol style="list-style-type: none"> Click add. Type the provider contract code in the Provider Contract field. Click Search. Select the provider contract from the search results list. Select the appropriate claim type from the Claim Type drop-down list. Enter an Effective date for the provider contract/claim type association. Enter an End date for the provider contract/claim type association. 	Update the end date to an existing provider contract/claim type	<ol style="list-style-type: none"> Click to select and view the desired provider contract/claim type crosswalk. Type a new end date in the *End Date field. 	Delete an association of a claim type from its existing provider contract	<ol style="list-style-type: none"> Click to select and view the desired provider contract/claim type crosswalk. Click delete. Click OK.
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Delete an association of a claim type from its existing provider contract	<ol style="list-style-type: none"> Click to select and view the desired provider contract/claim type crosswalk. Click delete. Click OK. 								
6	Click Save .								

Success

You have successfully completed this task when the provider contract and claim type information displays in the window.

Practice

Practice viewing the **Provider Contract/Claim Type** panel using this information:

- Access the Provider Contract/Claim Type panel.
- Sort the list by Claim Type.
- Resort list by Provider Contract.
- View the results.

Answer these questions regarding the results.

- Which claim types are associated with Provider Contract ASC?
- How many Provider Contracts can bill on a Claim type L? Which ones?

Practice updating the Provider Contract / Claim Type panel using this information:

- Access the Provider Contract/Claim Type panel.
- Access the provider contract you created (TST*** - your initials).
- Add claim type M.
- Use today's date for the Effective date.
- Use 12/31/2010 for the End date.

Summary

In this topic, you learned how add, update, and delete Provider Contract/Claim Type combinations.

Review

Objectives

In this course you learned how to:

- Define provider contracts as they relate to MITS and OHP policy
- Navigate to the provider contract panel
- View an existing provider contract
- Create and name a new provider contract
- Update a provider contract
- Navigate to/assign/deselect provider type/specialties for a provider contract
- Search for rules within provider contracts and the benefit groups
- Add, update, delete and inactivate rules for provider contracts
- Save rules
- Modify diagnosis editing for provider contract rules
- Update modifier editing for provider contract rules
- View the Conflict Report and correct any errors
- Add and maintain the provider contract/claim type crosswalk
- Add and maintain provider contract group types