



Pricing Manual
Kentucky MMIS Project

*Cabinet for Health and Family Services
Department for Medicaid Services*

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Cabinet for Health and Family Services Department for Medicaid Services	
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3.7	02/23/2010	Ron Chandler	Updated "Claim Type B: Physician Crossover (Prov Type 64/65), section per Mike Hudson and CO 13376. DMS approved 02/23/10
3.7	3/4/2010	Ron Chandler	Inserted "Claim Type C: Primary Care Crossover (Prov Type 31), and "Claim Type C Rural Health Crossover (Prov Type 35)" sections per Mike Hudson.No CO or DMS approval date needed they were just missing.
3.8	3/24/2010	Ron Chandler	Updated Renal Dialysis sections per Mike Hudson.
3.9	7/1/2010	Ron Chandler	Delete sentence in "Member Co-Pay, Post Waiver" section per Mike Hudson, verbal.
3.9.1	7/15/2010	Ron Chandler	Replace section Claim Type L – Nursing Facility (Provider Type 12), per Mike Hudson, in response to defect #12012 and DMS approval date of 7/15/2010.
3.9.2	7/21/2010	Ron Chandler	Replace CTM: Audiology (PT 50/70) per Mike Hudson, defect 14021, DMS approved 7/21/2010.
3.9.3	9/21/2010	Mike Hudson Ron Chandler	Replace "4.7.14 Claim Type I: Inpatient Hospital (Prov Type 01) – DRG Pricing/TDOS Greater Than 10/14/2007" table per Mike Hudson in response to CO 14226, DMS approved 9/20/2010.
3.9.4	11/02/2010	Pat Nolte Ron Chandler	Updated Claim Type M Physician and Nurse Practitioner per CO 14349, DMS approved on 10/29/2010.
3.9.5	12/6/2010	Pat Nolte Ron Chandler	Updated Claim type M for Nurse Practitioner (Prov Type 78) per CO 14700, DMS approved on 12/3/2010.

Version	Changed Date	Changed By	Reason
3.9.5	12/6/2010	Pat Nolte Ron Chandler	Updated Claim type M for Commission For Handicapped Children (CHC) (Prov Type 22) per CO 14720, DMS approved on 12/3/2010.
3.9.5	12/6/2010	Mike Hudson Ron Chandler	Updated Claim type M for Physician, under the multiple surgery section, the sentence after “modifier 26 being excluded” inserted the word “not” between “is” and “applied”, per Mike Hudson email. Also added sentence “There has to be at least TWO or more non-excluded surgical codes for the multiple surgery reduction to be applied.” at the end of the sentence.
3.9.5	12/6/2010	Mike Hudson Ron Chandler	Inserted Claim Type I: Inpatient Hospital/Non-DRG (Out-of State) – FDOS 09/01/2010 and After section in the manual
3.9.5	12/6/2010	Mike Hudson Ron Chandler	In section Claim Type I: Inpatient Hospital/Non-DRG (Out-of State/Non-Disproportionate Share) added a dash (-) and text “FDOS Prior to 09/01/2010”.
3.9.5	12/6/2010	Mike Hudson Ron Chandler	In section Claim Type I: Inpatient Hospital/Non-DRG (Out-of State/Disproportionate Share) added a dash (-) and text “FDOS Prior to 09/01/2010” per CO 14557.
3.9.6	12/10/2010	Mike Hudson Ron Chandler	Archived change log history as noted in 1 st row of this table above.
3.9.7	12/13/2010	Mike Hudson Ron Chandler	Revise “Claim Type P” section and reorder them per Mike Hudson.
3.9.8	03/08/2011	Pat Nolte Ron Chandler	Updated Claim Type M: Physician (Prov Type 64/65 and Claim Type M: Nurse Practitioner (Prov Type 78) according to CO 14936, DMS approved on 03/07/2011 per Pat Nolte email.
3.9.9	03/14/2011	Pat Nolte Ron Chandler	Revised table under Pathology Services for PT 64/65, claim type M per Pat Nolte email.

Version	Changed Date	Changed By	Reason
4.0	04/07/2011	Mike Hudson Ron Chandler	Replace “4.10.5 Claim Type O: Outpatient Hospital Emergency Room (Prov Type 01) Claims With Revenue Code 451” per Mike Hudson Email, in response to CO 15586, DMS approved 04/06/2011.
4.1	04/27/2011	Pam Hershey Ron Chandler	Insert “Case Cost Share (10/1/2008 – 12/31/2299)” section per Pam Hershey email in response to CO 3760, DMS approved 5/8/2009.
4.2	05/12/2011	Mike Hudson Ron Chandler	Replace “4.7.3 Claim Type I: Inpatient Hospital (PT 01) – DRG Pricing/TDOS Greater Than 10/14/2007” per Mike Hudson Email, in response to CO 15811, DMS approved 05/11/2011.
4.3	05/17/2011	Pat Nolte Ron Chandler	Replace Claim Type M: Ambulatory Surgical Center (ASC) (Prov Type 36) and Claim Type O: Renal Dialysis (Prov Type 39). Updates approved on 5/13/2011 by DMS for CO 15266.
4.3	05/17/2011	Pat Nolte Ron Chandler	Replace Claim Type M: Physician (Prov Type 64/65) and Claim Type M: Nurse Practitioner (Prov Type 78). Updates approved by DMS on 5/13/2011 for CO 15411.
4.4	05/19/2011	Pat Nolte Ron Chandler	Added text to “Provider Type 64/65, Claim Type M” section under “Physician Assistant” per Pat Nolte email.
4.5	08/02/2011	Mike Hudson Ann Murray	Replaced CT M: Physician and CT M: Practitioner per Mike Hudson for CO 15688.
4.6	08/09/2011	Pat Nolte Ann Murray	Updated the pricing manual for Claim Type O (PT 01). Updates were approved on 8/8/2011 by DMS under CO 15374.
4.7	08/18/2011	Mike Hudson Ron Chandler	Replace claim type M: Primary Care (Prov Type 31) and Claim Type M: Rural Health (Prov Type 35).

Version	Changed Date	Changed By	Reason
4.8	08/24/2011	Mike Hudson Ann Murray	The documentation for CO 13935 was approved on 07/19/2011. Replace the "Patient Liability – Waiver Claims", "Claim Type H: Home And Community Based Waiver", Claim Type M: Adult Day Care Center", "Claim Type M: Supports for Community Living", "Claim Type M: Acquired Brain Injury". Replace the "Rate Types" and added the "Claim Type M: Money Follows the Person (MFP) Pre-Transition Services".
4.9	11/17/2011	Mike Hudson Ann Murray	Replaced CT M:Nurse Practitioner per CO 15247.
5.0	01/13/2012	Mike Hudson Ann Murray	Replaced sections 4.10.2, 4.10.3, 4.10.4, 4.10.5 and 4.10.6 per CO 10857 Replaced CT M: Physician, CT M: Nurse Anesthetist and CT M: Nurse Practitioner per CO 16811.
5.1	02/07/2012	Pat Nolte Ann Murray	Updated Claim Type M: Durable Medical to read MX1, per request from Pat Nolte. No CO is associated with this request.
5.2	02/14/2012	Pat Nolte Ann Murray	Update Claim Type O, approved by DMS on 01/29/2012 under CO 16717.
5.3	03/01/2012	Mike Hudson Ron Chandler	Changed title page "client" block to read "Department for Medicaid Services Acting Commissioner Neville Wise".
5.4	03/19/2012	Mike Hudson Ann Murray	Replaced Waiver Patient Liability section per CO16780.
5.5	03/22/2012	Pat Nolte Ann Murray	Updated Claim type M for Preventive Health Services (Provider Type 20) as noted in CO 12294 per Pat Nolte, Task 17799.
5.6	03/26/2012	Pat Nolte Ann Murray	Updated Claim Typ D: Dental per CO 16634 approved by DMS on 3/25/2012. Updated Claim Type M: School Based Health Services per CO 16507 (16414) approved by DMS on 03/25/2012.
5.7	04/05/2012	Mike Hudson Ann Murray	Updated the Psych DRG flowchart per Mike Hudson.

Version	Changed Date	Changed By	Reason
5.8	05/07/2012	Pat Nolte Ann Murray	Updated Claim Type M: Physician and Nurse Practitioner per CO 17391 approved by DMS 05/05/2012.
5.9	08/02/2012	Pat Nolte Keri Hicks	Updated Claim Type M: Physician and Claim Type M: Podiatry per CO 16402 approved by DMS 07/08/2012.
6.0	8/14/2012	Pat Nolte Ron Chandler	Updated Claim Type M: Nurse Practitioner (Prov Type 78) per CO 16094 approved by DMS 08/12/2012

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1 Introduction

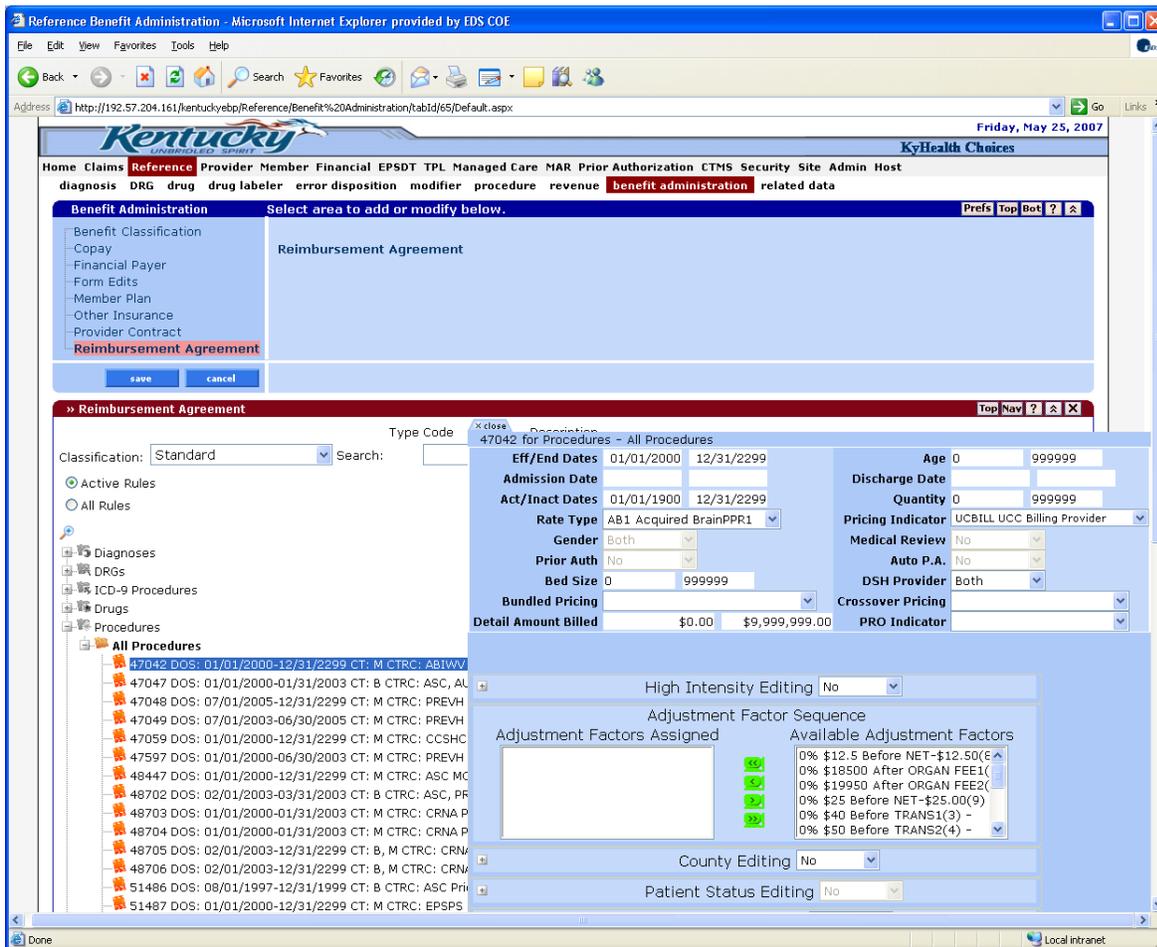
This manual is a guide to the methodology used to calculate Kentucky Title XIX claim reimbursement.

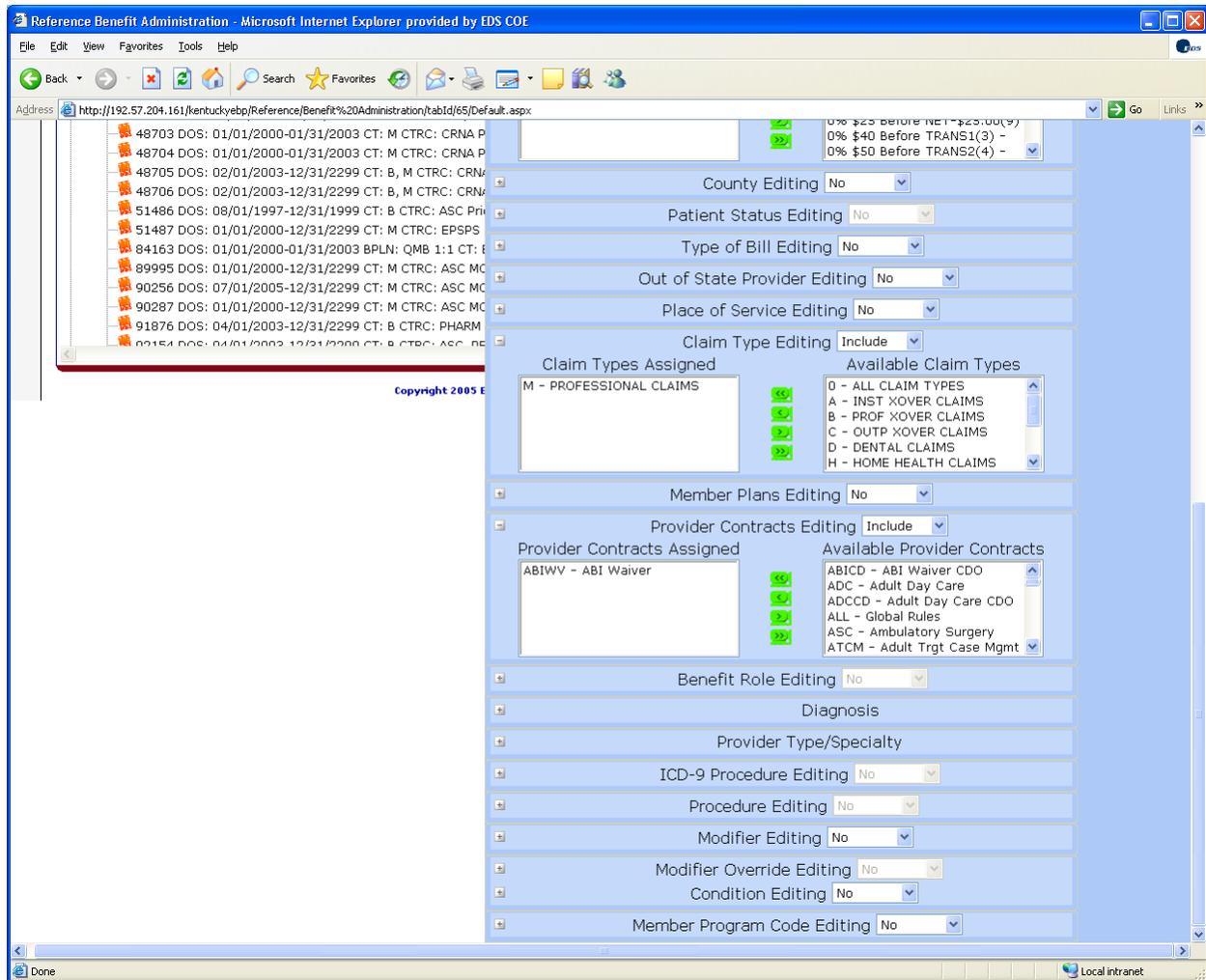
2 Pricing Data

2.1 Reimbursement Agreement

The reimbursement agreements (rules) are the mechanism used by the claims engine to identify a pricing methodology to be used while processing a claim. For more information about the reimbursement rules please refer to the Benefits Administration User Manual – Benefits Administration Reimbursement Rules.

A sample of the Reimbursement Agreement panel with a selected rule is displayed below.





Reimbursement Classifications used in Reimbursement Agreements

VALUE	REIMBURSEMENT AGREEMENT CLASSIFICATION DESCRIPTION
RC ABI CDO	Used for Acquired Brain Injury Consumer Directed Option
RC Adult Day Care	Used for Adult Day Care
RC Audiology	Used for Audiology
RC Comm Mental Healt	Used for Community Mental Health
RC Emer Transp	Used for Emergency Transportation
RC EPSDT	Used for EPSDT
RC Family Planning	Used for Family Planning
RC Fst Step/Erly Int	Used for First Step / Early Intervention
RC HANDS	Used for HANDS
RC HCB Waiver	Used for HCB Waiver
RC Hearing AidDealer	Used for Hearing Aid Dealer
RC Home Care Waiver	Used for Home Care Waiver
RC Home Health	Used for Home Health
RC Hospice	Used for Hospice
RC ICF/MR	Used for ICF/MR

VALUE	REIMBURSEMENT AGREEMENT CLASSIFICATION DESCRIPTION
RC Impact Plus	Used for Impact Plus
RC Inpat Hosp2	Used for Inpatient Hospital – Accommodation Codes – Non Acute Care Inpatient
RC Inpatient DRG	Used for Inpatient DRG
RC Inpatient Hospita	Used for Inpatient Hospital
RC Model Waiver	Used for Model II Waiver
RC Non-Emerg Trans	Used for Non-Emergency Transportation
RC Nursing Facility	Used for Nursing Facility
RC Optician	Used for Optician
RC Optometrist	Used for Optometrist
RC Oth lab and X-ray	Used for Other Lab & X-ray
RC Outpatient Hosp	Used for Outpatient Hospital
RC Personal Care Wvr	Used for Personal Care Waiver
RC Prev Health	Used for Preventative Health
RC PriCare/RuralHlth	Used for Primary Care & Rural Health
RC Professional Svcs	Used for Professional Services (i.e. Physician, Chiropractor, etc)
RC Psych Eating Dis	Used for Psych Eating Disorder
RC Psych Hospital	Used for Psych Hospital
RC Psych RTF	Used for Psych Residential Facility(ies)
RC Renal Dialysis	Used for Renal Dialysis
RC Schl Base Service	Used for School Based Services
RC SCL Waiver	Used for Support for Community Living Waiver
RC Title V/DSS	Used for Title V/DSS
RC Transplant	Used for Transplant procedures – Crossovers – Excluding Inpatient Hospital and Non Acute Care Inpt provider contracts
Rdg Behav Eating Dis	Used for Ridge Behavior Eating Disorder
Standard	This is the standard benefit classification. Used for rules that span multiple services for any provider contact(s) and parameters
Supp Comm Living CDO	Used for Support of Community Living – Consumer Directed Option
University Hsp RC278	Used for Kentucky University Hospital

2.2 Pricing Indicators (See the Pricing Indicator panel for the most current values – Reference subsystem)

VALUE	SHORT DESCRIPTION	LONG DESCRIPTION
ASC	Ambulatory Surgical Cntr	Pays the lesser of the ASC rate times units or the billed amount on the claim.
AUTMAN	Transplant Pricing	Pays the lesser of \$75,000 or 80% of the net billed charges.
AWP	Average Wholesale Price	Pharmacy and compound claims Quantity Dispensed times AWP Rate
BILLED	Pay as Billed	Pays the billed amount on the detail.
DRG	DRG	Pays the Diagnosis Related Groups (DRG) rate. DRG's are used nationwide as the basis for the analysis and prospective payment of hospital care. DRG pricing is performed on Inpatient claims.

VALUE	SHORT DESCRIPTION	LONG DESCRIPTION
DRGACF	DRG Acute Care Fac Trans	Pays the Diagnosis Related Groups (DRG) rate when transferring out of an acute care facility. DRG's are used nationwide as the basis for the analysis and prospective payment of hospital care. DRG pricing is performed on Inpatient claims.
DRGACN	DRG Tranfer Out Pricing (To Dates of Service after 10/14/2007)	Pays the Diagnosis Related Groups (DRG) rate when transferring out of an acute care facility. DRG's are used nationwide as the basis for the analysis and prospective payment of hospital care. DRG pricing is performed on Inpatient claims.
DRGPAF	DRG Post Acute Care Fac Trans	Pays the Diagnosis Related Groups (DRG) rate when transferring to a post acute care facility. DRG's are used nationwide as the basis for the analysis and prospective payment of hospital care. DRG pricing is performed on Inpatient claims.
DRGPAN	DRG Transfer to Post Acute/No Special Rule Pricing	Pays the Diagnosis Related Groups (DRG) rate when transferring to a post acute care facility and the special rule does not apply. DRG's are used nationwide as the basis for the analysis and prospective payment of hospital care. DRG pricing is performed on Inpatient claims.
DRGPAS	DRG Transfer to Post Acute/with Special Rule Pricing	Pays the Diagnosis Related Groups (DRG) rate when transferring to a post acute care facility and the special rule applies. DRG's are used nationwide as the basis for the analysis and prospective payment of hospital care. DRG pricing is performed on Inpatient claims.
DRGPSY	DRG Psych	Pays the Diagnosis Related Groups (DRG) rate for psychiatric care facilities. DRG's are used nationwide as the basis for the analysis and prospective payment of hospital care. DRG pricing is performed on Inpatient claims.
EAC	Estimate Acquisition cost	Pharmacy and compound claims that are priced using EAC rate for the detail.
FLTFEE	Flat Fee	Pays the revenue code flat rate. Does not multiply the rate by the units on the detail. Does not cutback to the lesser of the billed or allowed amount.
HSXWLK	Hospice Crosswalk Pricing	Pays the provider per unit rate times the units allowed unless there are specific exceptions met that will cause certain units on the detail to price at the MBRCTY (Member County) pricing method. Does not cutback to the lesser of the billed or allowed amount.
LEVCAR	Level of Care	Not Applicable
LMXUCC	Lesser of Max Fee or UCC	Pays the lesser of the max fee rate or the provider specific rate. Does not multiply the rate by the units on the detail. Does not cutback to the lesser of the billed or allowed amount.
LPAALW	Lesser PA/Max Fee Pric	Pays the lesser of the prior authorized (PA) unit rate (total dollars / total units) or the max fee rate times the units allowed. The lesser of this calculated allowed amount or the billed amount will be the actual paid amount.
LPABIL	Lesser of PA or Bill Amt	Pays the lesser of the prior authorized (PA) unit rate (total dollars / total units) or the billed unit rate times the number of allowed units.
LTCDME	LTCDME RevCode 410	Pays the lesser of the DME rental rate of the billed amount.

VALUE	SHORT DESCRIPTION	LONG DESCRIPTION
		There are some additional flat rates that are added based on specific modifiers and multiple services billed.
LTCLEV	LTC Leave Days	Not Applicable
LTCLOC	LTC Level of Care	Not Applicable
MAC	Max Allowable Cost	Pharmacy and compound claims that are priced using the MAC rate for the detail.
MANUAL	Manual	Suspends the claim for manual pricing if there is no prior authorization (PA) price on file for the service.
MAXFEE	Max Fee	Pays the max fee rate times the number of allowed units. Cuts back to the lesser of the billed amount or the allowed amount.
MAXFLT	Max Flat Fee	Pays the lesser of the max fee rate on file or the billed amount. Does not multiply the rate by the units on the detail.
MBRCTY	Member County Pricing	Pays the lesser of the member county rate times the units allowed or the billed amount.
MXFLT2	Max Flat Fee II	Pays the maximum rate on file. The rate is not multiplied by the units on the detail. Does not compare the maximum rate against the billed amount.
NDCLOW	NDC Lowest Price	Not Applicable. Gets the lesser of the SMAC, MAC, EAC, or AWP.
NFUNIT	UB92 Hospice LTC	Pays the NF1 rate type for the nursing facility ID submitted on the claim times the units allowed. Does not cutback to the lesser of the billed or allowed amount.
OPASC	Ambulatory Surgical Cntr	Pays the ASC rate associated with the procedure code submitted with an operating room (OR) revenue code. Additional special pricing logic is triggered by this pricing method for outpatient claims containing ASC services.
PCD100	Pay Xover 100% Detail	Pays 100% of the Medicare (crossover) coinsurance and deductible at 100% of the detail amount.
PCH100	Pay Xover 100% Header	Pays 100% of the Medicare (crossover) coinsurance and deductible at 100% of the header amount.
PCRURL	Per Diem Rate Reimburse	Pays the per diem rate once for the entire claim if a specific service (procedure) is found on the claim.
PMAXPD	Prov Max Per Diem	Pays the provider maximum per diem (non DRG inpatient claims).
PPCTUN	Percent of Per Diem Rate	Pays the provider specific percentage of the provider's per diem rate. Both the percentage and the per diem rate are contained on the same provider rate record.
PPDADD	Per Diem Add On	Pays the provider per diem and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.
PPRPCT	Provider Priced Percnt	Pays the provider specific percent of the billed amount.
PPRUNL	Provider Priced	Pays the lesser of the provider rate times the units allowed or the billed amount.
PPRUNT	Provider Priced Unit	Pays the provider (billing) rate times the units allowed. Does not cutback to the lesser of the billed or allowed amount.
REVFEE	Revenue Flat Fee	Pays the lesser of the revenue code flat rate times the units allowed or the billed amount.
REVMX1	Revenue Max Fee (no compare to billed)	Pays the max fee rate on file for the procedure code submitted with the revenue code times the units of service. Does <u>not</u>

VALUE	SHORT DESCRIPTION	LONG DESCRIPTION
		compare the allowed amount to the billed amount.
REVMXF	Revenue Max Fee (compare to billed)	Pays the lesser of (max fee rate for the procedure code submitted with the revenue code times the units allowed) or the billed amount.
REVPCT	Pay 75% of Billed Amount	Pays a provider specific percentage of the billed charges.
REVUNT	Revenue Unit	Pays a flat fee rate times the units allowed.
SBGRP	School Base Group	Pays the max fee rate times the number of allowed units divided by the number of students in the session. Cuts back to the lesser of the billed or allowed amount.
SMAC	State Max Allowable Cost	Pharmacy and compound claims that are priced using the SMAC rate for the detail.
SYSMAN	System Manual Price	The reimbursement rules control this pricing methodology. The system will attempt to price the claim using a prior authorization (PA) on file before the claim is suspended for manual intervention.
UCBILL	UCC Billing Provider	Pays the provider specific rate times the number of allowed units. Cuts back to the lesser of the billed or allowed amount.
UCCFL2	UCC Flat Fee II	Pays the provider specific rate. Does not multiply the rate by the units on the detail. Does not cutback to the lesser of the billed or allowed amount.
UCCFLT	UCC Flat Fee	Pays the lesser of the provider specific rate or the billed amount. Does not multiply the rate by the units on the claim.
UCPERF	Pay Prov Speci Rate (UCC)	Pays the provider (rendering/performing) rate times the units allowed. Does not cutback to the lesser of the billed or allowed amount.
ZEROPD	Zero Paid	Pays zero dollars (\$0.00). The status of the detail will be paid.

2.3 Rate Types (See the Rate Type panel for the most current values – Reference subsystem)

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
AB1	Acquired BrainPPR1	Rates from the provider procedure file Rate 1 Provider Type 17
AB2	Acquired BrainPPR2	Provider Type 17
AD1	Adult Day CarePPR1	Rates from the provider procedure file Rate 1 Provider Type 43
AD2	Adult Day Care PPR2	Provider Type 17
AD3	Adult Day Care PPR3	Provider Type 17
ADD	Add on Rate (used for add on rates for Inpatient non DRG claims)	Rates from the provider master file Mode 06 (add on fee) Provider Type 01
ASD	ASC Dental	Rates from the provider master file Mode 08 (outpatient percentage) Provider Type 36
CHC	Comm HandicapChild	Rates from the provider master file Mode 02 (Percentage) Provider Type 36
CM1	Comm Mental Hlth 1	Rates from the provider procedure file Rate 1 Provider Type 30
CM2	Comm Mental Hlth 2	Rates from the provider procedure file Rate 2 Provider Type 30
CM3	Comm Mental Hlth 3	Rates from the provider procedure file Rate 3 Provider Type 30
DEF	Default	Rates from the procedure rate file Technical & Professional Rate ASC Rate (G1 – G8) Rates from the provider master file Mode 34 (eating disorder per diem) Revenue Code – 129 Provider Type 02 - Provider – Ridge Behavioral Health Rates from the provider master file Mode 01 (per diem) Revenue Code – 100, 101, 114, 124, 180, 182, 183, 185 Provider Type 04 Rates from the provider master file Mode 01 (per diem) Revenue Code – 100 - 219 Provider Type 92, 93

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
DRG	DRG	Rates come from the DRG data file. All except DRG 424 – 433 & 521 – 523 get this rate type
DRP	DRG Psych	Rates come from the DRG data file. DRG's 424 – 433 & 521 – 523 get this rate type
DS1	DSH Per Diem	Rates from the provider master file Mode 01 (DSH Providers) Provider Type 01 (DSH provider)
DS2	DSH Per Diem In-ST	Rates from the provider master file Mode 03 (per diem/in-state disproportionate share) Provider Type 01 (DSH provider)
DSA	Max Per Diem	Rates from the provider master file Mode 09 (regular max per diem/out-of-state inpatient hospital bed size 000 - 050) Provider Type 01 (DSH provider)
DSB	Max Per Diem	Rates from the provider master file Mode 10 (regular max per diem/out-of-state inpatient hospital bed size 051 - 100) Provider Type 01 (DSH provider)
DSC	Max Per Diem	Rates from the provider master file Mode 11 (regular max per diem/out-of-state inpatient hospital bed size 101 - 200) Provider Type 01 (DSH provider)
DSD	Max Per Diem	Rates from the provider master file Mode 12 (regular max per diem/out-of-state inpatient hospital bed size 201 - 400) Provider Type 01 (DSH provider)
DSE	Max Per Diem	Rates from the provider master file Mode 13 (regular max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (DSH provider)
DSF	Max Per Diem	Rates from the provider master file Mode 14 (DSH max per diem/out-of-state inpatient hospital bed size 000 – 050) Provider Type 01 (DSH provider)
DSG	Max Per Diem	Rates from the provider master file Mode 15 (DSH max per diem/out-of-state inpatient hospital bed size 051 – 100) Provider Type 01 (DSH provider)
DSH	Max Per Diem	Rates from the provider master file Mode 16 (DSH max per diem/out-of-state inpatient hospital bed size 101 – 200) Provider Type 01 (DSH provider)
DSI	Max Per Diem	Rates from the provider master file Mode 17 (DSH max per diem/out-of-state inpatient hospital bed size 201 – 400) Provider Type 01 (DSH provider)

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
DSJ	Max Per Diem	Rates from the provider master file Mode 18 (DSH max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (DSH provider)
DSK	Max Per Diem	Rates from the provider master file Mode 19 (regular max per diem/out-of-state inpatient hospital bed size 000 - 050) Provider Type 01 (DSH provider)
DSL	Max Per Diem	Rates from the provider master file Mode 20 (regular max per diem/out-of-state inpatient hospital bed size 051 - 100) Provider Type 01 (DSH provider)
DSM	Max Per Diem	Rates from the provider master file Mode 21 (regular max per diem/out-of-state inpatient hospital bed size 101 - 200) Provider Type 01 (DSH provider)
DSN	Max Per Diem	Rates from the provider master file Mode 22 (regular max per diem/out-of-state inpatient hospital bed size 201 - 400) Provider Type 01 (DSH provider)
DSO	Max Per Diem	Rates from the provider master file Mode 23 (regular max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (DSH provider)
DSP	Max Per Diem	Rates from the provider master file Mode 24 (DSH max per diem/out-of-state inpatient hospital bed size 000 – 050) Provider Type 01 (DSH provider)
DSQ	Max Per Diem	Rates from the provider master file Mode 25 (DSH max per diem/out-of-state inpatient hospital bed size 051 – 100) Provider Type 01 (DSH provider)
DSR	Max Per Diem	Rates from the provider master file Mode 26 (DSH max per diem/out-of-state inpatient hospital bed size 101 – 200) Provider Type 01 (DSH provider)
DSS	Max Per Diem	Rates from the provider master file Mode 27 (DSH max per diem/out-of-state inpatient hospital bed size 201 – 400) Provider Type 01 (DSH provider)
DST	Max Per Diem	Rates from the provider master file Mode 28 (DSH max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (DSH provider)
DSU	Max Per Diem	Rates from the provider master file Mode 29 (regular max per diem/out-of-state psychiatric hospital) Provider Type 02 (DSH provider)

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
DSV	Max Per Diem	Rates from the provider master file Mode 30 (regular max per diem/out-of-state psychiatric hospital) Provider Type 02 (DSH provider)
DSW	Max Per Diem	Rates from the provider master file Mode 31 (regular max per diem/out-of-state psychiatric hospital) Provider Type 02 (DSH provider)
DSX	Max Per Diem	Rates from the provider master file Mode 32 (regular max per diem/out-of-state psychiatric hospital) Provider Type 02 (DSH provider)
EP1	EPSDT 1	Manually loaded these are the “WP###” procedure codes
FP1	Family Planning 1	Manually loaded to load the various modifiers for family planning
FPO	Family Plan Outpt	Rates from the procedure file Pricing Specialty of 0 with an end date <= 10/15/2003 Provider Type 32
HA0	HCB ABI LTC 430	Provider Type 42
HA1	HCB ABI LTC 440	Provider Type 42
HA2	HCB ABI LTC 550	Provider Type 42
HA3	HCB ABI LTC 589	Provider Type 42
HA4	HCB ABI LTC 900	Provider Type 42
HA5	HCB ABI LTC 916	Provider Type 42
HA6	HCB ABI LTC 660	Provider Type 42
HA7	HCB ABI LTC 420	Provider Type 42
HB0	HCB MichelleP 420	Provider Type 42
HB1	HCB MichelleP 430	Provider Type 42
HB2	HCB MichelleP 440	Provider Type 42
HB3	HCB MichelleP 551	Provider Type 42
HB4	HCB MichelleP 552	Provider Type 42
HB5	HCB MichelleP 580	Provider Type 42
HB6	HCB MichelleP 581	Provider Type 42
HB7	HCB MichelleP 582	Provider Type 42
HB8	HCB MichelleP 589	Provider Type 42
HB9	HCB MichelleP 590	Provider Type 42
HC1	HmCommWaiv Rev 551	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 551
HC2	HmCommWaiv Rev 552	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 552

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
HC3	HmCommWaiv Rev 580	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 580
HC4	HmCommWaiv Rev 581	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 581
HC5	HmCommWaiv Rev 582	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 582
HC6	HmCommWaiv Rev 590	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 590
HC7	HmCommWaiv Rev 410	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 410
HC8	HmCommWaiv Rev 852	Rates from the provider procedure file Rate 1 Provider Type 42 Revenue Code 852
HH1	HmHealth Rev 420	Rates from the provider procedure file Rate 1 Provider Type 34 Revenue Code 420
HH2	HOME HLTH PER CHRG	Rates from the provider master file Mode 02 (percentage) Provider Type 34 Revenue Code 270 – all dates Revenue Code 279 – all rows/dates with and end date <=6/30/2000
HH3	HOME HLTH PER CHRG	Rates from the provider master file Mode 33 (percentage) Provider Type 34 Revenue Code 279 – all rows/dates with and end date >=7/1/2000
HH4	HmHealth Rev 430	Rates from the provider procedure file Rate 1 Provider Type 34 Revenue Code 430
HH5	HmHealth Rev 440	Rates from the provider procedure file Rate 1 Provider Type 34 Revenue Code 440

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
HH6	HmHealth Rev 550	Rates from the provider procedure file Rate 1 Provider Type 34 Revenue Code 550
HH7	HmHealth Rev 560	Rates from the provider procedure file Rate 1 Provider Type 34 Revenue Code 560
HH8	HmHealth Rev 570	Rates from the provider procedure file Rate 1 Provider Type 34 Revenue Code 570
HO1	Member County Rate	Rates from the Hospice pricing file Revenue Code – 651, 652
HO3	Revenue Flat Fee	Manually loaded
HO4	Rev 656 Rate	Conversion to load
HO5	Rev 655 Rate	Conversion to load
HW1	HmCareWaiv Rev 581	Rates from the provider procedure file Rate 1 Provider Type 46 Revenue Code 581
HW2	HmCareWaiv Rev 582	Rates from the provider procedure file Rate 1 Provider Type 46 Revenue Code 582
HW3	HmCareWaiv Rev 590	Rates from the provider procedure file Rate 1 Provider Type 46 Revenue Code 590
IP1	Inpt Per Diem	Rates from the provider master file Mode 01 (Non-DSH Providers) Provider Type 01 (Non-DSH provider)
IPA	Reg Max Per Diem	Rates from the provider master file Mode 09 (regular max per diem/out-of-state inpatient hospital bed size 000 – 050) Provider Type 01 (Non-DSH provider)
IPB	Reg Max Per Diem	Rates from the provider master file Mode 10 (regular max per diem/out-of-state inpatient hospital bed size 051 – 100) Provider Type 01 (Non-DSH provider)
IPC	Reg Max Per Diem	Rates from the provider master file Mode 11 (regular max per diem/out-of-state inpatient hospital bed size 101 – 200) Provider Type 01 (Non-DSH provider)
IPD	Reg Max Per Diem	Rates from the provider master file Mode 12 (regular max per diem/out-of-state inpatient hospital bed size 201 – 400) Provider Type 01 (Non-DSH provider)

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
IPE	Reg Max Per Diem	Rates from the provider master file Mode 13 (regular max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (Non-DSH provider)
IPF	Reg Max Per Diem	Rates from the provider master file Mode 14 (DSH max per diem/out-of-state inpatient hospital bed size 000 – 050) Provider Type 01 (Non-DSH provider)
IPG	Reg Max Per Diem	Rates from the provider master file Mode 15 (DSH max per diem/out-of-state inpatient hospital bed size 051 – 100) Provider Type 01 (Non-DSH provider)
IPH	Reg Max Per Diem	Rates from the provider master file Mode 16 (DSH max per diem/out-of-state inpatient hospital bed size 101 – 200) Provider Type 01 (Non-DSH provider)
IPI	Reg Max Per Diem	Rates from the provider master file Mode 17 (DSH max per diem/out-of-state inpatient hospital bed size 201 – 400) Provider Type 01 (Non-DSH provider)
IPJ	Reg Max Per Diem	Rates from the provider master file Mode 18 (DSH max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (Non-DSH provider)
IPK	Reg Max Per Diem	Rates from the provider master file Mode 19 (regular max per diem/out-of-state inpatient hospital bed size 000 – 050) Provider Type 01 (Non-DSH provider)
IPL	Reg Max Per Diem	Rates from the provider master file Mode 20 (regular max per diem/out-of-state inpatient hospital bed size 051 – 100) Provider Type 01 (Non-DSH provider)
IPM	Reg Max Per Diem	Rates from the provider master file Mode 21 (regular max per diem/out-of-state inpatient hospital bed size 101 – 200) Provider Type 01 (Non-DSH provider)
IPN	Reg Max Per Diem	Rates from the provider master file Mode 22 (regular max per diem/out-of-state inpatient hospital bed size 201 – 400) Provider Type 01 (Non-DSH provider)
IPO	Reg Max Per Diem	Rates from the provider master file Mode 23 (regular max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (Non-DSH provider)
IPP	Reg Max Per Diem	Rates from the provider master file Mode 24 (DSH max per diem/out-of-state inpatient hospital bed size 000 – 050) Provider Type 01 (Non-DSH provider)

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
IPQ	Reg Max Per Diem	Rates from the provider master file Mode 25 (DSH max per diem/out-of-state inpatient hospital bed size 051 – 100) Provider Type 01 (Non-DSH provider)
IPR	Reg Max Per Diem	Rates from the provider master file Mode 26 (DSH max per diem/out-of-state inpatient hospital bed size 101 – 200) Provider Type 01 (Non-DSH provider)
IPS	Reg Max Per Diem	Rates from the provider master file Mode 27 (DSH max per diem/out-of-state inpatient hospital bed size 201 – 400) Provider Type 01 (Non-DSH provider)
IPT	Reg Max Per Diem	Rates from the provider master file Mode 28 (DSH max per diem/out-of-state inpatient hospital bed size 401+) Provider Type 01 (Non-DSH provider)
IPU	Reg Max Per Diem	Rates from the provider master file Mode 29 (regular max per diem/out-of-state psychiatric hospital) Provider Type 02 (Non-DSH provider)
IPV	Reg Max Per Diem	Rates from the provider master file Mode 30 (DSH max per diem/out-of-state psychiatric hospital) Provider Type 02 (Non-DSH provider)
IPW	Reg Max Per Diem	Rates from the provider master file Mode 32 (DSH max per diem/out-of-state psychiatric hospital) Provider Type 02 (Non-DSH provider)
IPX	Reg Max Per Diem	Rates from the provider master file Mode 31 (regular max per diem/out-of-state psychiatric hospital) Provider Type 02 (Non-DSH provider)
MFP	Money Follows the Person Procedure/Revenue Code Rates	Rates from the PDD File (Procedure Code Max Fee and Revenue Code Flat Fee)
MR1	Prov Unit Per Diem	Rates from the provider master file Mode 01 (Per Diem) Revenue Codes – 110, 120, 130, 140, 150, 160, 180, 185
MR2	Prov Percent	Rates from the provider master file Mode 05 (Nursing Facility Ancillary) Revenue Codes – 300–314, 320, 410, 420, 430, 440
MW1	Model Waiv Rev 410	Rates from the provider procedure file Rate 1 Provider Type 41 Revenue Code 410
MW2	Model Waiv Rev 552	Rates from the provider procedure file Rate 1 Provider Type 41 Revenue Code 552

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
MW3	Model Waiv Rev 559	Rates from the provider procedure file Rate 1 Provider Type 41 Revenue Code 559
MX1	MAX FLAT FEE 1	Rates from the PDD file Medicaid Rate 1
MX2	MAX FLAT FEE 2	Rates from the PDD file Medicaid Rate 2
N1A	Non Emerg Trans 1A	Manually loaded
N1B	Non Emerg Trans 1B	Manually loaded
N2A	Non Emerg Trans 2A	Manually loaded
N2B	Non Emerg Trans 2B	Manually loaded
N2C	Non Emerg Trans 2C	Manually loaded
N2D	Non Emerg Trans 2D	Manually loaded
N2E	Non Emerg Trans 2E	Manually loaded
N2F	Non Emerg Trans 2F	Manually loaded
N2G	Non Emerg Trans 2G	Manually loaded
N7A	Non Emerg Trans 7A	Manually loaded
N7B	Non Emerg Trans 7B	Manually loaded
N8A	Non Emerg Trans 8A	Manually loaded
N8B	Non Emerg Trans 8B	Manually loaded
NA	Not Applicable	Needed for pricing methods MANUAL, PCD100, PCH100, and AUTMAN.
NF1	NURSE FAC DAILY UN	Rates from the provider master file Mode 01 (per diem) Provider Type 44 Revenue Codes – 155, 183, 185 Rates from the provider master file Mode 01 (per diem) Provider Type 12 Revenue Codes – 110, 120, 130, 140, 150, 160, 180, 185
NF2	NURSE FAC DAILY %	Rates from the provider master file Mode 05 (nursing facility ancillary rate) Provider Type 12
NF3	INFECTIOUS DISEASE	Rates from the provider master file Mode 01 (per diem) Provider Type 12 FYI – Rates not applicable on and after 11/1/2003, but segments on Legacy went to the end of time.

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
NF4	NF BRAIN INJURY	Rates from the provider master file Mode 06 (Per Diem/Brain Injury – Behavioral Unit (Nursing Facility Only)) Provider Type 12 FYI – Rates not applicable on and after 11/1/2003, but segments on Legacy went to the end of time.
NT2	Non Emerg Trans T2	Manually loaded
OP1	OUTPTNT Percent 1	Rates from the provider master file Mode 08 (outpatient percentage) Provider Type 01
OP2	OUTPTNT Percent 2	Conversion to load
OP3	OUTPTNT Percent 3	Manually loaded
OP4	OUTPTNT Percent 4	Manually loaded
OP5	OUTPTNT Percent 5	Manually loaded
OP6	OUTPTNT Percent 6	Manually loaded
OPA	OUTPTNT ASC	Rates from the procedure rate file ASC Rate S1 – S8
OT1	Optician/Optomtri	Manually loaded
P3O	Dental Rates Outpt	Rates from the procedure rate file Inpatient Rate Pricing specialty 3
P4I	ProfProc InptRate4	Rates from the procedure rate file Inpatient Rate Pricing specialty 4
P4O	ProfProc Out Rate4	Rates from the procedure rate file Outpatient Rate Pricing specialty 4
P5O	Prof Proc OutRate5	Rates from the procedure rate file Outpatient Rate Pricing specialty 5
P6O	Prof Proc OutRate6	Rates from the procedure rate file Outpatient Rate Pricing specialty 6
P8O	Prof Proc OutRate8	Rates from the procedure rate file Outpatient Rate Pricing specialty 8
P9O	Prof Proc OutRate9	Rates from the procedure rate file Outpatient Rate Pricing specialty 9 Revenue Code 410
PCC	Prim Care Center	Rates from the provider master file Mode 01 (per diem) Provider Type 31

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
PED	Psych Eat Disorder	Rates from the provider master file Mode 34 (Eating Disorder Per Diem Rate) Provider Type 02
PH1	Prev Hlth SvcRate1	Manually loaded
PH2	Prev Hlth SvcRate2	Manually loaded
PH3	Prev Hlth SvcRate3	Manually loaded
PSI	POS/Lab Inpatient	Rates from the procedure rate file 62% Rate Pricing specialty 5
PSO	POS/Lab Outpatient	Rates from the procedure rate file 60% Rate Pricing specialty 5
PW1	PCare Waiv Rev 581	Rates from the provider procedure file Rate 1 Provider Type 47 Revenue Code 581
PW2	PCare Waiv Rev 590	Rates from the provider procedure file Rate 1 Provider Type 47 Revenue Code 590
PW3	PCare Waiv Rev 942	Rates from the provider procedure file Rate 1 Provider Type 47 Revenue Code 942
RD1	RDialysis Rev 821	Rates from the provider procedure file Rate 1 Provider Type 39 Revenue Code 821
RD2	DIALYSIS PERC RATE	Rates from the provider master file Mode 08 (outpatient percentage) Provider Type 39 Revenue Codes – 250, 270, 320, 632, 635, 636, 730, 821, 855, 920
RD3	RDialysis Rev 831	Rates from the provider procedure file Rate 1 Provider Type 39 Revenue Code 831
RD4	RDialysis Rev 841	Rates from the provider procedure file Rate 1 Provider Type 39 Revenue Code 841
RD5	RDialysis Rev 851	Rates from the provider procedure file Rate 1 Provider Type 39 Revenue Code 851
RD6	RDialy MaxFeeDrug	Rates for Renal Dialysis (PT 39) revenue code 636 (based on the procedure code submitted with the revenue code)

VALUE	DESCRIPTION	ADDITIONAL INFO (XREF TO OLD SYSTEM)
RH1	Rural Hlth 1	Rates from the provider master file Mode 01 (per diem) Provider Type 35
RH2	Rural Hlth 2	Rates from the provider master file Mode 02 (percentage) Provider Type 35
SBS	School Based Svcs	Manually loaded
SC1	Supp for Comm Liv1	Rates from the provider procedure file Rate 1 Provider Type 33
SC2	Supp for Comm Liv2	Rates from the provider procedure file Rate 2 Provider Type 33
SC3	Supp for Comm Liv3	Rates from the provider procedure file Rate 3 Provider Type 33
SC4	Supp for Comm Liv4	Rates from the provider procedure file Rate 4 Provider Type 33
SC5	Supp for Comm Liv5	Provider Type 33
SC6	Supp for Comm Liv6	Provider Type 33
TR1	TranMile UA POS 23	Manually loaded
TR2	TranMile UA POS 99	Manually loaded
TR3	TranMile UB POS 23	Manually loaded
TR4	TranMile UB POS 99	Manually loaded
TR5	TranXPas UA POS 23	Manually loaded
TR6	TranXpas UA POS 99	Manually loaded
TR7	Tran Base UC	Manually loaded
TV1	Title V PPR1	Rates from the provider procedure file Rate 1 Provider Type 23

2.4 Crosswalk – interChange Rate Types to “Legacy” Provider Master File

Below is quick cross reference to associate old provider rate modes to interchange rate types for DSH and non-DSH providers.

The first column identifies the provider type, the second column identifies if it's a Per Diem or a percentage, the third column is a reference to the previous system (legacy) mode value, the fourth and fifth columns identify the interchange rate type.

Prov TYPE	New Pricing Methodology	Provider Rate File PROV_CHRG_MODE	NON DSH Rate Type	DSH Rate Type
ALL	Provider Per Diem	Mode = 06	ADD	
01	DSH (one occurrence mode = 03) Provider Per Diem	Mode = 01		DS1
01	Provider Per Diem	Mode = 01 Value of 110%	IP1	
01	Provider Per Diem (provider with mode = 03 are Disp Share (DSH) providers)	Mode = 03		DS2
01	Provider Percentage	Mode = 08	OP1	
01	Provider Percentage	Mode = 08 Value of 65%	OP2	
01	Provider Per Diem	Mode = 29 Mode = 30 Mode = 31 Mode = 32	IPU IPV IPW IPX	DSU DSV DSW DSX
01	Provider Per Diem with Mode from Provider Rate File column and a Mode = 02	Mode = 09 Mode = 10 Mode = 11 Mode = 12 Mode = 13 Mode = 19 Mode = 20 Mode = 21 Mode = 22 Mode = 23	IPA IPB IPC IPD IPE IPK IPL IPM IPN IPO	DSA DSB DSC DSD DSE DSK DSL DSM DSN DSO

Prov TYPE	New Pricing Methodology	Provider Rate File PROV_CHRG_MODE	NON DSH Rate Type	DSH Rate Type
01	Provider Per Diem with Mode from Provider Rate File column and a Mode = 04	Mode = 14 Mode = 15 Mode = 16 Mode = 17 Mode = 18 Mode = 24 Mode = 25 Mode = 26 Mode = 27 Mode = 28	IPF IPG IPH IPI IPJ IPP IPQ IPR IPS IPT	DSF DSG DSH DSI DSJ DSP DSQ DSR DSS DST
02	DSH (one occurrence mode = 03) Provider Per Diem	Mode = 01		DS1
02	Provider Per Diem	Mode = 01 Value of 110%	IP1	
02	Provider Per Diem (Provider with Mode = 03 are Disp Share (DSH) Providers)	Mode = 03		DS2
02	Provider Per Diem	Mode = 29 Mode = 30 Mode = 31 Mode = 32	IPU IPV IPW IPX	DSU DSV DSW DSX
02	Provider per Diem with Mode from Provider Rate File column and a Mode = 02	Mode = 09 Mode = 10 Mode = 11 Mode = 12 Mode = 13 Mode = 19 Mode = 20 Mode = 21 Mode = 22 Mode = 23	IPA IPB IPC IPD IPE IPK IPL IPM IPN IPO	DSA DSB DSC DSD DES DSK DSL DSM DSN DSO
02	Provider per Diem with Mode from Provider Rate File column and a Mode = 04 is for DSH	Mode = 14 Mode = 15 Mode = 16 Mode = 17 Mode = 18 Mode = 24 Mode = 25 Mode = 26 Mode = 27 Mode = 28	IPF IPG IPH IPI IPJ IPP IPQ IPR IPS IPT	DSF DSG DSH DSI DSJ DSP DSQ DSR DSS DST

Prov TYPE	New Pricing Methodology	Provider Rate File PROV_CHRG_MODE	NON DSH Rate Type	DSH Rate Type
02	Provider Per Diem	Mode = 34	PED	
04	Provider Per Diem	Mode = 01	DEF	
11	Provider Per Diem	Mode = 01	MR1	
11	Provider Percentage	Mode = 01	MR2	
12	Provider Per Diem	Mode = 01 Effective Date prior to 7/1/2005	NF1	
12	Provider Per Diem	Mode = 01 Effective Date on or after 7/1/2005 Value 100% or 75% or 50% based on the specific Provider ID: Rates are on the Provider Rate panel. Select Provider Enter Provider ID Select Search From the navigation panel Select Provider Rate	NF1	
12	Provider Per Diem	Mode = 03	NF1	
12	Provider Percentage	Mode = 05	NF2	
22	Provider Percentage	Mode = 02	DEF	
31	Provider Per Diem	Mode = 01	DEF	
34	Provider Percentage	Mode = 01	HH1	
34	Provider Percentage	Mode = 02	HH2	
34	Provider Percentage	Mode = 33	HH3	
35	Provider Per Diem	Mode = 01	RH1	
35	Provider Percentage	Mode = 02	RH2	
39	Provider Percentage	Mode = 08	RD2	
92	Provider Per Diem	Mode = 01	DEF	
93	Provider Per Diem	Mode = 01	DEF	

Prov TYPE	New Pricing Methodology	Provider Rate File PROV_CHRG_MODE	NON DSH Rate Type	DSH Rate Type

2.5 Health Program Panel

The Health Program panel is where you can quickly identify what pricing method and what rate type was used for processing and pricing a claim service. The various pricing methods/indicators and rate types are described in table at the beginning of this manual.

Once you have this information, you can use it to review other panels (benefit adjustment factor – BAF, rates, error, EOB, provider ID, etc) to understand how and why the claim priced.

The screenshot shows the 'Claims Information' web application. The 'Health Program' panel is active, displaying a table with the following data:

Header/Detail Number	Paid Amount	State Share Amount	Federal Share Amount	Encounter Amount	Allowed Amount	Allowed Quantity	CoPay Amount	Aid Category	Rate	Pricing Indicator	Managed Care Indicator	Fund Code	Financial Payer	Health Program
1	\$109.43	\$0.00	\$0.00	\$0.00	\$109.43	1.00	\$0.00	M	P40	MAXFEE		A	DEF	GCECP

Below the table, the 'Health Program' panel contains several fields for configuration and search:

- Detail Number:** 1
- Pricing Indicator:** Choice encounter (P)
- Managed Care Indicator:** Choice encounter (P)
- Fund Code:**
- Member Assignment:**
- Financial Payer:** [Search]
- Health Program:** [Search]
- Payable Benefit:**
- Covered Benefit:**
- Benefit Hierarchy:**
- Assignment Hierarchy:**
- Payer Hierarchy:**

On this panel, for this paid Physician claim, the MAXFEE pricing method was used (Pricing Indicator) using a rate type (Rate Type) of P40 for service 99285 (procedure) with a service date of 1/16/2007 (FDOS & TDOS).

2.6 Benefit Adjustment Factor (BAF)

The Benefit Adjustment Factor (BAF) is also identified by the reimbursement rules. BAFs provide the ability to alter an existing allowed amount by a percentage or a series of percentages to increase the allowed amount or reduce it by the percentage assigned. This type of adjustment works in conjunction to pricing methodologies to apply a percentage to the allowed amount. This enhancement allows the user to alter a rate utilizing different criteria without having to create new rates.

The BAFs can also be used to pay additional set amounts that are not service related. The purpose of set amounts for a BAF is to add or subtract that amount to the calculated allowed amount after the specific pricing methodology was applied. This allows for a reduction of rate types and maintenance in the reference files.

The combination of percentages and incentive amounts are allowable as well as multiple BAFs per single pricing methodology. The BAF provides the user with a “before (B)”/”after (A)” flag. When the “before” flag is used, it compares the billed amount against the calculated allowed amount including the BAF and takes the lesser of the two values.

The BAF calculation uses the BAF values (percentage and/or flat amount) along with the calculated allowed amount to get the amount to be compared to the billed amount.

An example:

Detail one has a billed amount of \$100.00.

Detail one’s calculated allowed amount = \$110.00 and has a BAF “before” flag of 90% and no additional flat rate.

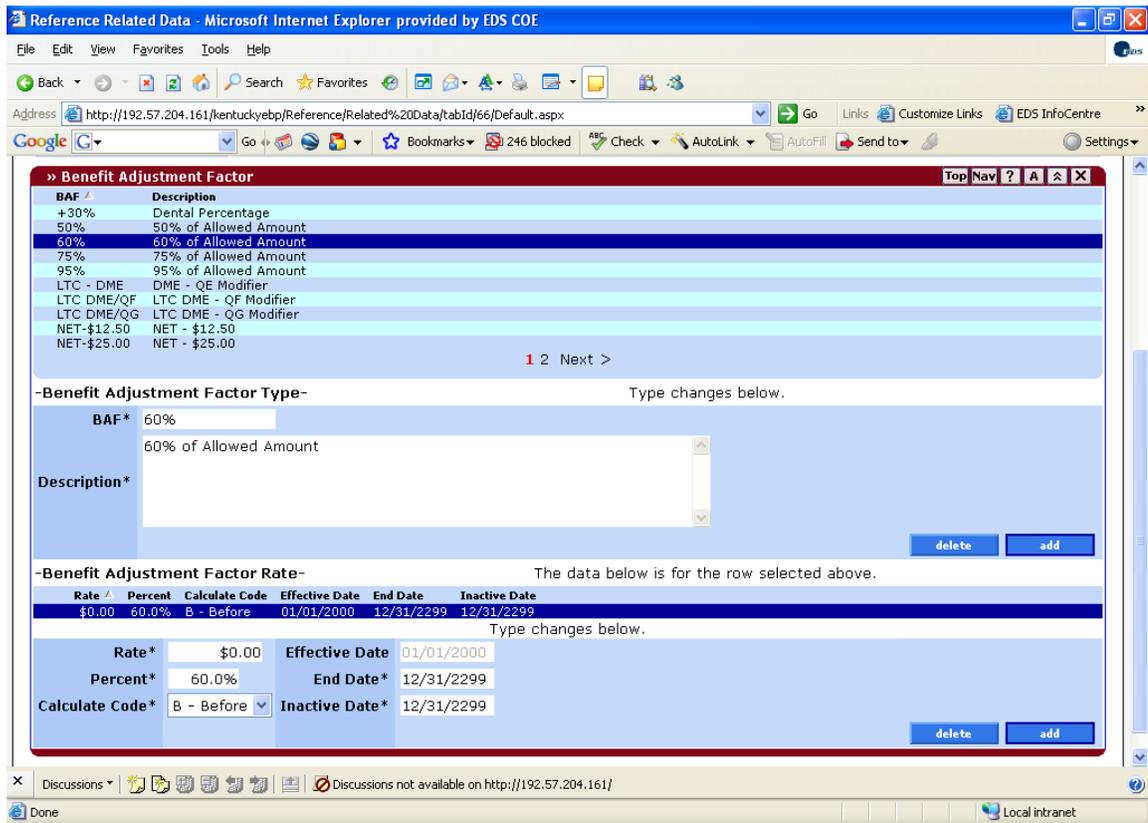
“Before” BAF calculation $\$99.00 = (\$110.00 * .9) + 0$

[(calculated allowed amount * BAF percentage) + flat rate]

The billed amount is greater than the BAF calculated value, so the BAF calculated amount (\$99.00) is used as the allowed amount for the detail.

If the flag is “after” (A), then no comparison is performed between the billed amount and calculated allowed amount including the BAF.

Benefit Adjustment Factor name and description maintenance screen (Reference subsystem).



Inactive Date

A required field that displays Date the Procedure/Modifier combination can no longer be used regardless of dates of service on the claim. As long as the processing date is before the inactive date specified in the segment, the segment is considered to be an active segment. The system auto plugs a default date of 12/31/2299 that can be updated by the user when the segment is inactivated.

2.7 Max Fee Rates (T_MAX_FEE table)

The Max Fee panel is used to view to maintain the max fee allowed amount for a procedure code or procedure code/modifier combination. Max Fee data is user maintained and entered based on KY pricing policy.

Navigation Path: [Reference - Procedure] - [(select HCPCS)] - [(select row from search results)] - [(select Max Fee)]

Procedure Maintenance Select an area to add or modify Prefs Top Bot ? ▲

Procedure Restriction

Base Information Top Nav ? A ▼ X

» Max Fee Top Nav ? A ▲ X

Modifier	Modifier2	Modifier3	Modifier4	Rate Type	Allowed Amount	Relative Value	Effective Date	End Date	Inactive Date
				P4I - ProfProc InptRate4	\$36.98	0.0	07/01/1996	12/31/2299	12/31/2299
				P4O - ProfProc Out Rate4	\$36.98	0.0	07/01/1996	12/31/2299	12/31/2299
				P4O - ProfProc Out Rate4	\$34.32	0.0	12/13/1994	06/30/1996	12/31/2299
				P4I - ProfProc InptRate4	\$34.32	0.0	12/13/1994	06/30/1996	12/31/2299
				P4I - ProfProc InptRate4	\$48.00	0.0	07/01/1991	12/12/1994	12/31/2299
				P4O - ProfProc Out Rate4	\$64.00	0.0	07/01/1991	12/12/1994	12/31/2299
				P4I - ProfProc InptRate4	\$32.00	0.0	07/01/1990	06/30/1991	12/31/2299
				P4O - ProfProc Out Rate4	\$41.60	0.0	07/01/1990	06/30/1991	12/31/2299

Type changes below.

Modifier [Search] Effective Date

Modifier2 [Search] End Date*

Modifier3 [Search] Inactive Date*

Modifier4 [Search]

Rate Type

Allowed Amount*

Relative Value*

2.8 Usual and Customary Charge (UCC) Rates (T_REF_UCC table)

The Provider Customary Charge panel maintains the Usual Customary Charge (UCC) rates.

Navigation Path: [Provider - Search] - [select row from search results] - [Customary Charge]

Provider Maintenance Select area to add or modify below.

Provider: [Service Location]

Account Recoup Maximum
CLIA Maintenance
DEA
Disproportionate Share Rate
Group
Language

Board Participant
Contract
Dispensing Fee
EFT Account
Group Member
License

Certification
Customary Charge
Disproportionate Share
Facility
IDs
Medicare Number

save cancel

Service Location

Base Information

Customary Charge

Procedure	Modifier 1	Modifier 2	Modifier 3	Modifier 4	UCC Rate	Rate Type	Effective Date	End Date	Inactive Date
99199					\$1,483.32	Title V PPR1	07/01/1998	06/30/1999	12/31/2299
99199					\$1,639.14	Title V PPR1	07/01/1999	06/30/2000	12/31/2299
99199					\$912.11	Title V PPR1	07/01/1996	06/30/1997	12/31/2299
99199					\$1,528.28	Title V PPR1	07/01/1997	06/30/1998	12/31/2299
99199					\$1,673.29	Title V PPR1	07/01/2002	06/30/2003	12/31/2299
99199					\$1,692.54	Title V PPR1	07/01/2003	12/31/2299	12/31/2299
99199					\$1,673.29	Title V PPR1	07/01/2000	06/30/2001	12/31/2299
99199					\$1,692.54	Title V PPR1	07/01/2001	06/30/2002	12/31/2299
99244					\$1,800.00	Title V PPR1	07/01/2002	12/31/2299	12/31/2299
99245					\$3,100.00	Title V PPR1	07/01/2002	12/31/2299	12/31/2299

1 2 3 4 Next >

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

Procedure [Search] Effective Date []

Modifier 1 [Search] End Date []

Modifier 2 [Search] Inactive Date []

Modifier 3 [Search] UCC Rate []

Modifier 4 [Search] Rate Type []

2.9 Provider Rates (T_PR_RATE table)

The Provider Rate panel maintains multiple provider specific institutional and professional reimbursement rates including per diem, per unit, and percentage-of-charge rates.

Navigation Path: [Provider - Search] - [select row from search results] - [Provider Rate]

The screenshot displays a web application window titled "Provider Information - Microsoft Internet Explorer provided by EDS COE". The browser address bar shows the URL: `http://192.57.204.161/kentuckyebp/Provider/Information/tabId/71/Default.aspx?SAK_PROV=5000097778SAK_PROV_LOC`. The main content area is divided into several sections:

- Provider Maintenance:** A menu titled "Select area to add or modify below." with options: Language, License, Medicare Number, Owner, Payment Pull, Physician Assistant, Provider Beds, Provider Contract Rate, Provider DRG Rate, Provider EDI, Provider Location Name Address, Provider Pharmacy Lockin, **Provider Rate**, Restricted Service, Review, Service Location, State Share, Supervising Physician, and TPRR. The "Provider Rate" option is highlighted.
- Service Location:** A section header.
- Base Information:** A section header.
- Provider Rate:** A table listing existing rates. Below the table is a form for adding or modifying a rate.

Rate Type	Flat Rate Amount	Percentage Amount	Active Date	Inactive Date	Effective Date	End Date
OUTPTNT Percent 2	\$0.00	65.0%	08/05/2003	12/31/2299	08/01/2003	11/30/2003
OUTPTNT Percent 1	\$0.00	36.0%	06/11/2002	12/31/2299	06/10/2002	07/31/2003
OUTPTNT Percent 1	\$0.00	42.0%	08/05/2003	12/31/2299	08/01/2003	11/30/2003
OUTPTNT Percent 1	\$0.00	37.0%	12/04/2003	12/31/2299	12/01/2003	02/05/2004
OUTPTNT Percent 2	\$0.00	65.0%	12/04/2003	12/31/2299	12/01/2003	02/05/2004
OUTPTNT Percent 1	\$0.00	65.0%	03/07/2000	12/31/2299	09/01/1999	03/14/2001
OUTPTNT Percent 2	\$0.00	65.0%	03/07/2000	12/31/2299	09/01/1999	03/14/2001
OUTPTNT Percent 2	\$0.00	65.0%	03/14/2001	12/31/2299	03/15/2001	06/09/2002
OUTPTNT Percent 2	\$0.00	65.0%	06/11/2002	12/31/2299	06/10/2002	07/31/2003
OUTPTNT Percent 1	\$0.00	37.0%	03/14/2001	12/31/2299	03/15/2001	06/09/2002

Below the table, there is a form for adding or modifying a rate:

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

Rate Type:

Flat Rate Amount:

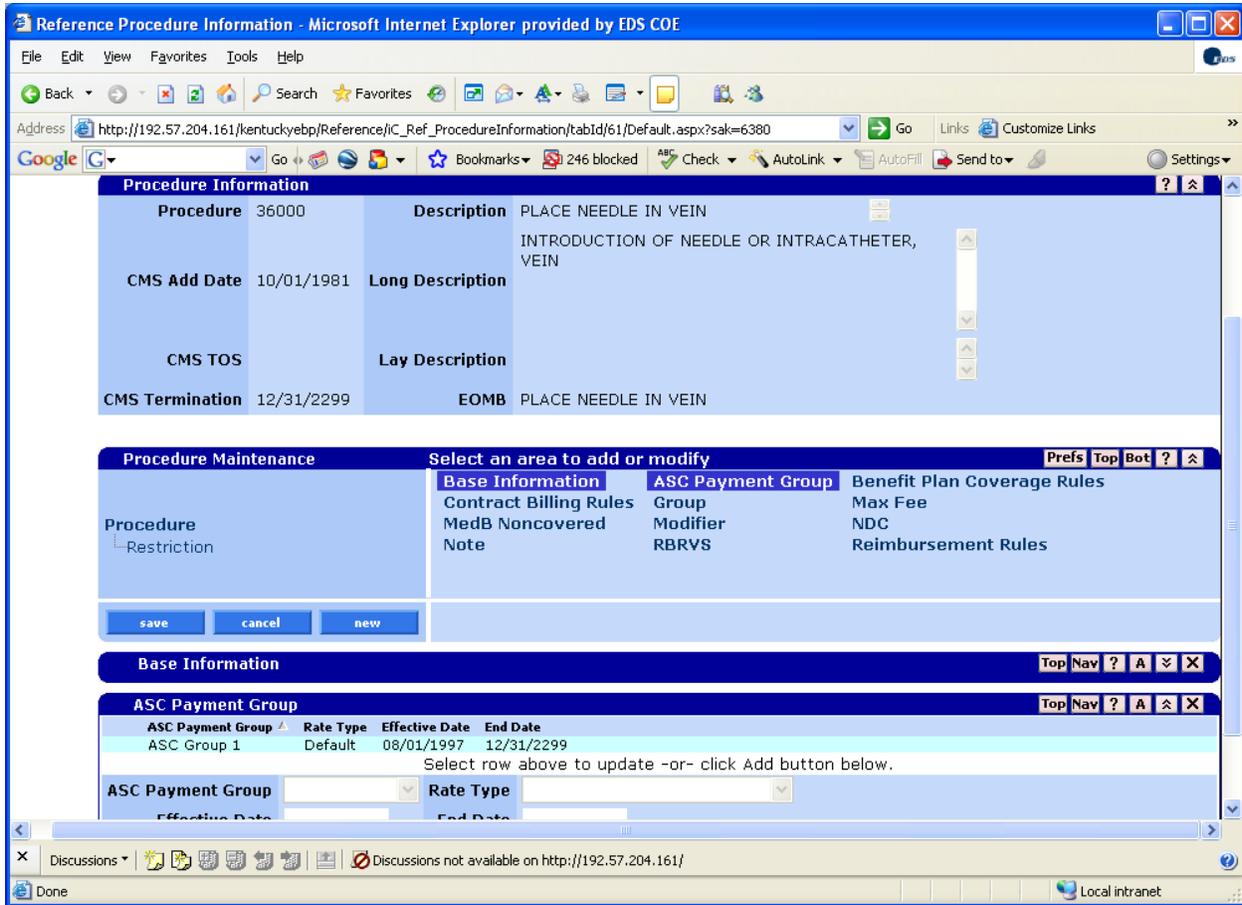
Percentage Amount:

Active Date: Effective Date:

2.10 ASC Rates (T_PROC_ASC, T_ASC_PRICING tables)

The ASC Payment Group panel allows the user to view the Ambulatory Surgical Center groups assigned to a procedure. The ASC group is used to determine the ASC rate paid on a claim. These rates come from CMS on an annual basis. Kentucky has not update these rates for several years.

Navigation Path: [Reference - Procedure] - [{ click on 'search' button }] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [ASC Payment Group]



The ASC pricing panel allows the user to view and maintain the reimbursement rates paid to providers for a Ambulatory Surgical Center (ASC) procedure. The rates are based upon the classifications of procedures into different payment groups that are based on surgical procedure complexity. Rates by payment group are established by CMS.

Navigation Path: [Reference - Related Data] - [Other] - [ASC Pricing]

The screenshot shows a web browser window titled "Reference Related Data - Microsoft Internet Explorer provided by EDS COE". The address bar shows the URL: http://192.57.204.161/kentuckyebp/Reference/Related%20Data/tabId/66/Default.aspx. The page features a navigation menu with "Reference" selected. Below the menu, there is a "Related Data" section with a sub-menu where "ASC Pricing" is selected. The main content area displays a table of ASC Pricing data.

ASC Payment Group	Rate Type	Effective Date	End Date	Amount
ASC Group 1	OUTPTNT ASC	08/01/2003	12/31/2299	\$397.00
ASC Group 1	Default	08/01/1997	12/31/2299	\$307.38
ASC Group 2	OUTPTNT ASC	08/01/2003	12/31/2299	\$534.00
ASC Group 2	Default	08/01/1997	12/31/2299	\$412.79
ASC Group 3	Default	08/01/1997	12/31/2299	\$471.90
ASC Group 3	OUTPTNT ASC	08/01/2003	12/31/2299	\$610.00
ASC Group 4	OUTPTNT ASC	08/01/2003	12/31/2299	\$753.00
ASC Group 4	Default	08/01/1997	12/31/2299	\$582.25
ASC Group 5	Default	08/01/1997	12/31/2299	\$664.02
ASC Group 5	OUTPTNT ASC	08/01/2003	12/31/2299	\$858.00

2.11 DRG Rates (T_PR_DRG_RATE and T_DRG_RATE tables)

The Provider DRG Rate panel maintains provider specific Diagnosis Related Group rates.

Navigation Path: [Provider - Search] - [select row from search results] - [Provider DRG Rate]

Prefs T
» Provider Maintenance
Select area to add or modify below.

Provider Service Location	EFT Account IDs Medicare Number Physician Assistant Provider Document Images Provider Location Name Address Provider Date	Facility Language Owner Provider Beds Provider DRG Rate Provider Medical Lockin Provider Fee Service Period	Group Practice Provider Participates In License Payment Pull Provider Contract Rate Provider EDI Provider Pharmacy Lockin Restricted Services
-------------------------------------	---	---	---

Service Location Top Nav

Base Information Top Nav

Provider DRG Rate Top Nav

DRG	Description	Operating Base Rate	Cost Charge Rate	Rate Type	Effective Date	End Date	Inactive Date
0000	Default DRG Rates	\$3,761.78	55.20%	DRG - DRG	04/01/2003	11/30/2003	12/31/2299
0000	Default DRG Rates	\$3,821.92	55.20%	DRG - DRG	12/01/2003	06/30/2004	12/31/2299
0000	Default DRG Rates	\$3,998.80	55.50%	DRG - DRG	07/01/2004	06/30/2005	12/31/2299
0000	Default DRG Rates	\$4,366.77	49.30%	DRG - DRG	07/01/2005	06/30/2006	12/31/2299
0000	Default DRG Rates	\$4,453.08	43.40%	DRG - DRG	07/01/2006	10/14/2007	12/31/2299
0000	Default DRG Rates	\$3,440.06	43.40%	DRG - DRG	10/15/2007	11/14/2007	12/31/2299
0000	Default DRG Rates	\$3,411.52	43.40%	DRG - DRG	11/15/2007	06/15/2008	12/31/2299
0000	Default DRG Rates	\$4,453.08	43.40%	DRG - DRG	06/16/2008	12/31/2299	12/31/2299
0000	Default DRG Rates	\$777.47	0.00%	DRP - DRG Psych	04/01/2003	10/31/2003	12/31/2299
0000	Default DRG Rates	\$613.77	0.00%	DRP - DRG Psych	11/01/2003	12/31/2299	12/31/2299

Type changes below.

DRG* 0000 [Search] Description Default DRG Rates Operating Base Rate* \$4,453.08 Cost Charge Rate 43.40% Capital Cost Rate* \$392.89 High Intensity add-on* \$0.00 Cost outlier Number* \$29,000.00 Inactive Date* 12/31/2299	Effective Date 06/16/2008 End Date* 12/31/2299 Rate Type DRG - DRG Capital IME Factor* 30.85% Operating IME Factor* 31.62% Cost outlier Percentage* 80.00%
--	---

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The DRG Rate panel is used to update, delete and add rates and indicators for the selected DRG code. Users are able to key effective and end segments with pricing parameters that include rate type, weight, Ky geometric length of stay, average length of stay, post acute transfer indicator, and special rule indicator.

Navigation Path: [Reference – DRG] [DRG - Search] - [(select row from search results)] - [Rates]

DRG Information

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DRG 0088 Description

DRG Maintenance Select an area to add or modify

- Base Information
- Benefit Plan Coverage Rules
- Contract Billing Rules
- Group
- MDC List
- Note
- Rates
- Reimbursement Rules

Base Information

Rates

Rate Type	Weight	GEO Length of Stay	Length of Stay	PAC Ind	Sp. Rule Ind	Effective Date	End Date	Inactive Date
DRG	0.5499	0.0	4.0	No	No	04/01/2003	11/30/2003	12/31/2299
DRG	0.5609	0.0	4.0	No	No	12/01/2003	04/09/2004	12/31/2299
DRG	0.5499	0.0	4.0	No	No	04/10/2004	06/30/2004	12/31/2299
DRG	0.5627	0.0	4.0	No	No	07/01/2004	06/30/2005	12/31/2299
DRG	0.5356	0.0	4.0	No	No	07/01/2005	01/31/2006	12/31/2299
DRG	0.6267	0.0	4.0	No	No	02/01/2006	06/30/2006	12/31/2299
DRG	0.6000	0.0	4.0	No	No	07/01/2006	10/14/2007	12/31/2299
DRG	0.6000	2.8	3.4	No	No	10/15/2007	12/31/2299	12/31/2299

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

Rate Type: Effective Date:

End Date: Weight:

GEO Length of Stay: Length of Stay:

PAC Ind: Special Rule Ind:

Inactive Date:

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2.12 Revenue Code Flat Rates (T_REVENUE_FLAT_FEE table)

The Flat Fee panel is used to maintain specific revenue codes that have a different reimbursement rate based on rate types.

Navigation Path: [Reference - Revenue] - [(select row from search results)] - [Flat Fee]

The screenshot shows a web browser window titled "Reference Revenue Information - Microsoft Internet Explorer provided by EDS COE". The address bar shows a URL ending in "SAK_REVENUE=421". The application interface includes a navigation menu with "Reference" selected, and a search bar with "Revenue" entered. Below the search bar, the "Revenue Information" section displays details for revenue code 481, described as "CARDIC CATH LAB", with an effective date of 01/01/1964 and an end date of 12/31/2299. The "Revenue Maintenance" section offers options to add or modify information, with "Flat Fee" selected. The "Flat Fee" table below shows a list of entries with columns for Emergency Code, Flat Fee Amount, Effective Date, Rate Type, and End Date. The table contains four rows of data. Below the table is a form to add a new flat fee entry, with fields for Emergency Code (set to "Emergency"), Flat Fee Amount, Effective Date, and Rate Type, and an "add" button.

Emergency Code	Flat Fee Amount	Effective Date	Rate Type	End Date
No Emergency	\$1,770.00	08/04/2003	OP6 OUTPTINT Percent 6	12/31/2299
No Emergency	\$1,478.00	08/04/2003	OP5 OUTPTINT Percent 5	12/31/2299
No Emergency	\$1,420.00	09/01/2002	OP5 OUTPTINT Percent 5	08/03/2003
No Emergency	\$1,700.00	09/01/2002	OP6 OUTPTINT Percent 6	08/03/2003

NOTE: The Emergency Code column is just informational it is not used.

2.13 Member County Rates (T_COUNTY_RATE table)

This County Rate panel will be used to maintain the T_COUNTY_RATE table, which is populated with rate information.

Navigation Path: [Reference – Related Date - Other] – [County Rate]

The screenshot shows a web browser window titled "Reference Related Data - Microsoft Internet Explorer provided by EDS COE". The address bar shows the URL: http://192.57.204.161/kentuckyebp/Reference/Related%20Data/tabId/66/Default.aspx. The page features a navigation menu with "Reference" selected. Below the menu, there is a "Related Data" section with a "select area to add or modify below" dropdown menu. The "County Rate" option is selected. Below this, a table displays the "County Rate" data for Adair county. The table has columns for County, Revenue Code, Rate Type, Amount, Effective Date, End Date, Active Date, and Inactive Date. The data shows multiple entries for Adair county with various revenue codes and rates. At the bottom of the table, there are search fields for County, Revenue Code, Rate Type, and Amount.

County	Revenue Code	Rate Type	Amount	Effective Date	End Date	Active Date	Inactive Date
Adair	652	HO1 - Member County Rate	\$27.12	10/01/2005	09/30/2006	01/01/1900	12/31/2299
Adair	652	HO1 - Member County Rate	\$28.01	10/01/2006	12/31/2299	01/01/1900	12/31/2299
Adair	652	HO1 - Member County Rate	\$26.61	10/01/2004	09/30/2005	01/01/1900	12/31/2299
Adair	652	HO1 - Member County Rate	\$24.86	10/01/2002	09/30/2003	01/01/1900	12/31/2299
Adair	652	HO1 - Member County Rate	\$25.91	10/01/2003	09/30/2004	01/01/1900	12/31/2299
Adair	651	HO1 - Member County Rate	\$111.62	10/01/2005	09/30/2006	01/01/1900	12/31/2299
Adair	651	HO1 - Member County Rate	\$115.29	10/01/2006	12/31/2299	01/01/1900	12/31/2299
Adair	651	HO1 - Member County Rate	\$109.54	10/01/2004	09/30/2005	01/01/1900	12/31/2299
Adair	651	HO1 - Member County Rate	\$102.31	10/01/2002	09/30/2003	01/01/1900	12/31/2299
Adair	651	HO1 - Member County Rate	\$106.65	10/01/2003	09/30/2004	01/01/1900	12/31/2299

2.14 Provider/Member Contract Rates (T_PR_CONTRACT_RATE table)

The Provider Contract Rate panel maintains provider specific contracted percentage-of-charge rates. This is most often used for out of state organ transplants. The rate is for a specific billing provider, member, and date of service.

Navigation Path: [Provider - Search] - [select row from search results] - [Provider Contract Rate]

Prefs Top Bot
» Provider Maintenance Select area to add or modify below.

Provider Service Location	IDs Medicare Number Physician Assistant Provider Document Images Provider Location Name Address Provider Rate	Language Owner Provider Beds Provider DRG Rate Provider Medical Lockin Providers in Group Practice	License Payment Pull Provider Contract Rate Provider EDI Provider Pharmacy Lockin Restricted Service
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save cancel

Service Location Top Nav A

Base Information Top Nav A

Provider Contract Rate Top Nav A

Member ID	Member Name	Percent Contract Rate	Claim Type	First Date Service	End Date Service
0000000000	Member, Name A	40.0%	INPATIENT CLAIMS	05/18/2004	09/29/2005
0000000000	Member, Name B	40.0%	OUTPATIENT CLAIMS	05/18/2004	09/29/2005
0000000000	Member, Name C	68.0%	INPATIENT CLAIMS	02/01/2006	05/04/2006
0000000000	Member, Name D	68.0%	OUTPATIENT CLAIMS	02/01/2006	05/04/2006
0000000000	Member, Name E	68.0%	INPATIENT CLAIMS	08/01/2005	08/21/2006
0000000000	Member, Name F	68.0%	OUTPATIENT CLAIMS	08/01/2005	08/21/2006
0000000000	Member, Name G	68.0%	INPATIENT CLAIMS	12/26/2006	12/31/2299
0000000000	Member, Name H	68.0%	OUTPATIENT CLAIMS	12/26/2006	12/31/2299
0000000000	Member, Name I	68.0%	INPATIENT CLAIMS	12/11/2005	12/12/2006
0000000000	Member, Name J	68.0%	OUTPATIENT CLAIMS	12/11/2005	12/12/2006

1 2 3 4 5 6 7 8 Next >

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

Member ID	<input type="text" value=""/> [Search]		
Member Name	<input type="text" value=""/>	First Date Service	<input type="text" value=""/>
Percent Contract Rate	<input type="text" value=""/>	End Date Service	<input type="text" value=""/>
Claim Type	<input type="text" value=""/>	<input type="button" value="add"/>	

2.15 Hospice Revenue Crosswalk (T_REV_HOSPICE_XWALK table)

No panel exists at this time. This table maintains the data to specially price certain hospice services at a different service rate.

Below is a the data that exists on this table:

SAK HOSPICE XWALK	SAK REV CLAIM	DTE EFFECTIVE	DTE END	DTE ACTIVE	DTE INACTIVE	QTY UNITS MIN	QTY UNITS MAX	CDE UNIT TYPE	SAK REV PRICE
1	274	19000101	22991231	01-JAN-00	31-DEC-99	0	999	L	271
2	273	19000101	22991231	01-JAN-00	31-DEC-99	1	5	L	271
3	273	19000101	22991231	01-JAN-00	31-DEC-99	6	999	L	271

2.16 Multiple Surgery Percentages (T_CLM_MULT_SURG table)

No panel exists at this time. This table maintains the percentage of the multiple surgery reductions. This table uses sequence to and sequence from to identify the highest percentage to be paid and the preceding percentages.

Below is the data that exists on this table:

SAK MULT SURG	SEQ FROM	SEQ TO	DTE EFFECTIVE	DTE END	MULT SURG PERCENT	DTE INACTIVE
1	1	1	19000101	22991231	1	22991231
2	2	50	19000101	22991231	.5	22991231

2.17 Default Pricing Percentages (T_DEFAULT_PRICING table)

No panel exists at this time. When default pricing is called, this table contains the various percentages of the billed amount to be calculated for a given set of parameters (i.e. provider type, place of service, date of service, etc).

Below is a the data that exists on this table:

SAK DEF PRICE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PROC TYPE	DTE EFFECTIVE	DTE END	PCT DEFAULT	CDE PROC MOD	CDE RATE TYPE	IND METHOD	DTE ACTIVE	DTE INACTIVE
100	20	000			-1	19000101	22991231	0			P	01-JAN-00	31-DEC-99
200	36	000			-1	20021001	22991231	.45			P	01-JAN-00	31-DEC-99
201	36	000			-1	19000101	20020930	.65			P	01-JAN-00	31-DEC-99
300	37	000			-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
400	50	000			-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
500	52	000			3072	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
501	52	000		11	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
502	52	000		12	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
503	52	000		13	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
504	52	000		14	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
505	52	000		15	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
506	52	000		20	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
507	52	000		21	-1	19000101	22991231	.5			P	01-JAN-00	31-DEC-99
508	52	000		22	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
509	52	000		23	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
510	52	000		24	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
511	52	000		25	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
512	52	000		26	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
513	52	000		31	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
514	52	000		32	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
515	52	000		33	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
516	52	000		34	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
517	52	000		41	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
518	52	000		42	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
519	52	000		49	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
520	52	000		50	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
521	52	000		51	-1	19000101	2299123 1	.5			P	01-JAN-00	31-DEC-99
522	52	000		52	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
523	52	000		53	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
524	52	000		54	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
525	52	000		55	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
526	52	000		56	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
527	52	000		57	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
528	52	000		60	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
529	52	000		61	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
530	52	000		62	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
531	52	000		65	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
532	52	000		71	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
533	52	000		72	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
534	52	000		81	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
535	52	000		99	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRICE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PROC TYPE	DTE EFFECTIVE	DTE END	PCT DEFAULT	CDE PROC MOD	CDE RATE TYPE	IND METHOD	DTE ACTIVE	DTE INACTIVE
700	60	000	D	11	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
701	60	000	D	12	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
702	60	000	D	21	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
703	60	000	D	22	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
704	60	000	D	31	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
705	60	000	D	35	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
800	61	000	D	11	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
801	61	000	D	12	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
802	61	000	D	21	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
803	61	000	D	22	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
804	61	000	D	31	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
805	61	000	D	35	-1	19900701	22991231	.65			P	01-JAN-00	31-DEC-99
900	64	000		11	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
901	64	000		11	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
902	64	000		12	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
903	64	000		12	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
904	64	000		13	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
905	64	000		13	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
906	64	000		14	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
907	64	000		14	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
908	64	000		15	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
909	64	000		15	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
910	64	000		20	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
911	64	000		20	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
912	64	000		21	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
913	64	000		21	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
914	64	000		22	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
915	64	000		22	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
916	64	000		23	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
917	64	000		23	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
918	64	000		24	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
919	64	000		24	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
920	64	000		25	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
921	64	000		25	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
922	64	000		26	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
923	64	000		26	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
924	64	000		31	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
925	64	000		31	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
926	64	000		32	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
927	64	000		32	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
928	64	000		33	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
929	64	000		33	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
930	64	000		34	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
931	64	000		34	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
932	64	000		41	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
933	64	000		41	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
934	64	000		42	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
935	64	000		42	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
936	64	000		49	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
937	64	000		49	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
938	64	000		50	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
939	64	000		50	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
940	64	000		51	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
941	64	000		51	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
942	64	000		52	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
943	64	000		52	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
944	64	000		53	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
945	64	000		53	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
946	64	000		54	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
947	64	000		54	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
948	64	000		55	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
949	64	000		55	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
950	64	000		56	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
951	64	000		56	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
952	64	000		57	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
953	64	000		57	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
954	64	000		60	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
955	64	000		60	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
956	64	000		61	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
957	64	000		61	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
958	64	000		62	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
959	64	000		62	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
960	64	000		65	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
961	64	000		65	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
962	64	000		71	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
963	64	000		71	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
964	64	000		72	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
965	64	000		72	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
966	64	000		81	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
967	64	000		81	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
968	64	000		99	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
969	64	000		99	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1000	64	000			3072	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
1101	64	000			3072	19941213	2299123 1	.65	26	DEF	X	01-JAN-00	31-DEC-99
1102	64	000			3072	19941213	2299123 1	.65	TC	DEF	X	01-JAN-00	31-DEC-99
1200	64	000		11	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1201	64	000		11	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1202	64	000		11	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1203	64	000		11	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1204	64	000		12	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1205	64	000		12	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1206	64	000		12	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1207	64	000		12	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1208	64	000		13	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1209	64	000		13	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1210	64	000		13	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1211	64	000		13	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1212	64	000		14	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1213	64	000		14	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1214	64	000		14	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1215	64	000		14	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1216	64	000		15	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1217	64	000		15	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1218	64	000		15	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1219	64	000		15	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1220	64	000		20	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1221	64	000		20	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1222	64	000		20	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1223	64	000		20	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1224	64	000		21	-1	19941213	20040101	.5				01-JAN-00	31-DEC-99
1225	64	000		21	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1226	64	000		21	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1227	64	000		21	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
1228	64	000		22	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1229	64	000		22	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1230	64	000		22	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1231	64	000		22	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1232	64	000		23	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1233	64	000		23	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1234	64	000		23	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1235	64	000		23	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1236	64	000		24	-1	19941213	20040101	.5				01-JAN-00	31-DEC-99
1237	64	000		24	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1238	64	000		24	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1239	64	000		24	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1240	64	000		25	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1241	64	000		25	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1242	64	000		25	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1243	64	000		25	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1244	64	000		26	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1245	64	000		26	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1246	64	000		26	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1247	64	000		26	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1248	64	000		31	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1249	64	000		31	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1250	64	000		31	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1251	64	000		31	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1252	64	000		32	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1253	64	000		32	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1254	64	000		32	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1255	64	000		32	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1256	64	000		33	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1257	64	000		33	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1258	64	000		33	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1259	64	000		33	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1260	64	000		34	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1261	64	000		34	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1262	64	000		34	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1263	64	000		34	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1264	64	000		41	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1265	64	000		41	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1266	64	000		41	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1267	64	000		41	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1268	64	000		42	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1269	64	000		42	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1270	64	000		42	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1271	64	000		42	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1272	64	000		49	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
1273	64	000		49	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1274	64	000		49	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1275	64	000		49	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1276	64	000		50	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1277	64	000		50	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1278	64	000		50	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1279	64	000		50	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1280	64	000		51	-1	19941213	2004010 1	.5				01-JAN-00	31-DEC-99
1281	64	000		51	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1282	64	000		51	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1283	64	000		51	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1284	64	000		52	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1285	64	000		52	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1286	64	000		52	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1287	64	000		52	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1288	64	000		53	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1289	64	000		53	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1290	64	000		53	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1291	64	000		53	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1292	64	000		54	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1293	64	000		54	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1294	64	000		54	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1295	64	000		54	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1296	64	000		55	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1297	64	000		55	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1298	64	000		55	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1299	64	000		55	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1300	64	000		56	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1301	64	000		56	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1302	64	000		56	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1303	64	000		56	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1304	64	000		57	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1305	64	000		57	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1306	64	000		57	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1307	64	000		57	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1308	64	000		60	-1	19941213	20040101	.65				01-JAN-00	31-DEC-99
1309	64	000		60	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1310	64	000		60	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1311	64	000		60	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1312	64	000		61	-1	19941213	20040101	.5				01-JAN-00	31-DEC-99
1313	64	000		61	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99
1314	64	000		61	-1	20040801	20060731	.65				01-JAN-00	31-DEC-99
1315	64	000		61	-1	20060801	22991231	.45				01-JAN-00	31-DEC-99
1316	64	000		62	-1	19941213	20040101	.5				01-JAN-00	31-DEC-99
1317	64	000		62	-1	20040102	20040731	.45				01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
1318	64	000		62	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1319	64	000		62	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1320	64	000		65	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1321	64	000		65	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1322	64	000		65	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1323	64	000		65	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1324	64	000		71	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1325	64	000		71	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1326	64	000		71	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1327	64	000		71	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1328	64	000		72	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1329	64	000		72	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1330	64	000		72	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1331	64	000		72	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1332	64	000		81	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1333	64	000		81	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1334	64	000		81	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1335	64	000		81	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99
1336	64	000		99	-1	19941213	2004010 1	.65				01-JAN-00	31-DEC-99
1337	64	000		99	-1	20040102	2004073 1	.45				01-JAN-00	31-DEC-99
1338	64	000		99	-1	20040801	2006073 1	.65				01-JAN-00	31-DEC-99
1339	64	000		99	-1	20060801	2299123 1	.45				01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1400	65	000		11	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1401	65	000		11	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1402	65	000		12	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1403	65	000		12	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1404	65	000		13	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1405	65	000		13	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1406	65	000		14	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1407	65	000		14	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1408	65	000		15	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1409	65	000		15	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1410	65	000		20	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1411	65	000		20	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1412	65	000		21	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1413	65	000		21	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1414	65	000		22	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1415	65	000		22	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1416	65	000		23	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1417	65	000		23	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1418	65	000		24	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1419	65	000		24	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1420	65	000		25	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1421	65	000		25	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1422	65	000		26	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
1423	65	000		26	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1424	65	000		31	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1425	65	000		31	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1426	65	000		32	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1427	65	000		32	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1428	65	000		33	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1429	65	000		33	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1430	65	000		34	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1431	65	000		34	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1432	65	000		41	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1433	65	000		41	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1434	65	000		42	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1435	65	000		42	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1436	65	000		49	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1437	65	000		49	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1438	65	000		50	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1439	65	000		50	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1440	65	000		51	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1441	65	000		51	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1442	65	000		52	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1443	65	000		52	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1444	65	000		53	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1445	65	000		53	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1446	65	000		54	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1447	65	000		54	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1448	65	000		55	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1449	65	000		55	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1450	65	000		56	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1451	65	000		56	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1452	65	000		57	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1453	65	000		57	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1454	65	000		60	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1455	65	000		60	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1456	65	000		61	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1457	65	000		61	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1458	65	000		62	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1459	65	000		62	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1460	65	000		65	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1461	65	000		65	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1462	65	000		71	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1463	65	000		71	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1464	65	000		72	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1465	65	000		72	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1466	65	000		81	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
1467	65	000		81	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
1468	65	000		99	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
1469	65	000		99	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
1600	65	000			3072	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
1601	65	000			3072	19941213	2299123 1	.65	26	DEF	X	01-JAN-00	31-DEC-99
1602	65	000			3072	19941213	2299123 1	.65	TC	DEF	X	01-JAN-00	31-DEC-99
1700	65	000		11	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1701	65	000		11	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1702	65	000		11	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1703	65	000		11	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1704	65	000		12	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1705	65	000		12	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1706	65	000		12	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1707	65	000		12	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1708	65	000		13	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1709	65	000		13	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1710	65	000		13	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1711	65	000		13	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1712	65	000		14	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1713	65	000		14	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1714	65	000		14	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1715	65	000		14	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1716	65	000		15	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1717	65	000		15	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1718	65	000		15	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1719	65	000		15	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1720	65	000		20	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1721	65	000		20	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1722	65	000		20	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1723	65	000		20	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1724	65	000		21	-1	19941213	20040101	.5			P	01-JAN-00	31-DEC-99
1725	65	000		21	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1726	65	000		21	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1727	65	000		21	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1728	65	000		22	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1729	65	000		22	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1730	65	000		22	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1731	65	000		22	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1732	65	000		23	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1733	65	000		23	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1734	65	000		23	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1735	65	000		23	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1736	65	000		24	-1	19941213	20040101	.5			P	01-JAN-00	31-DEC-99
1737	65	000		24	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1738	65	000		24	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1739	65	000		24	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99

SAK DEF PRICE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PROC TYPE	DTE EFFECTIVE	DTE END	PCT DEFAULT	CDE PROC MOD	CDE RATE TYPE	IND METHOD	DTE ACTIVE	DTE INACTIVE
							1						
1740	65	000		25	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1741	65	000		25	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1742	65	000		25	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1743	65	000		25	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1744	65	000		26	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1745	65	000		26	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1746	65	000		26	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1747	65	000		26	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1748	65	000		31	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1749	65	000		31	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1750	65	000		31	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1751	65	000		31	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1752	65	000		32	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1753	65	000		32	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1754	65	000		32	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1755	65	000		32	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1756	65	000		33	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1757	65	000		33	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1758	65	000		33	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1759	65	000		33	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1760	65	000		34	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1761	65	000		34	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1762	65	000		34	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1763	65	000		34	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1764	65	000		41	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1765	65	000		41	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1766	65	000		41	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1767	65	000		41	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1768	65	000		42	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1769	65	000		42	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1770	65	000		42	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1771	65	000		42	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1772	65	000		49	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1773	65	000		49	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1774	65	000		49	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1775	65	000		49	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1776	65	000		50	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1777	65	000		50	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1778	65	000		50	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1779	65	000		50	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1780	65	000		51	-1	19941213	20040101	.5			P	01-JAN-00	31-DEC-99
1781	65	000		51	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1782	65	000		51	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1783	65	000		51	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1784	65	000		52	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
1785	65	000		52	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1786	65	000		52	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1787	65	000		52	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1788	65	000		53	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1789	65	000		53	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1790	65	000		53	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1791	65	000		53	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1792	65	000		54	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1793	65	000		54	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1794	65	000		54	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1795	65	000		54	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1796	65	000		55	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1797	65	000		55	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1798	65	000		55	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1799	65	000		55	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1800	65	000		56	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1801	65	000		56	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1802	65	000		56	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1803	65	000		56	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1804	65	000		57	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1805	65	000		57	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1806	65	000		57	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
1807	65	000		57	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1808	65	000		60	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1809	65	000		60	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1810	65	000		60	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1811	65	000		60	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1812	65	000		61	-1	19941213	2004010 1	.5			P	01-JAN-00	31-DEC-99
1813	65	000		61	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1814	65	000		61	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1815	65	000		61	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1816	65	000		62	-1	19941213	2004010 1	.6			P	01-JAN-00	31-DEC-99
1817	65	000		62	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1818	65	000		62	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1819	65	000		62	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1820	65	000		65	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1821	65	000		65	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1822	65	000		65	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1823	65	000		65	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1824	65	000		71	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1825	65	000		71	-1	20040102	2004073 1	.45			P	01-JAN-00	31-DEC-99
1826	65	000		71	-1	20040801	2006073 1	.65			P	01-JAN-00	31-DEC-99
1827	65	000		71	-1	20060801	2299123 1	.45			P	01-JAN-00	31-DEC-99
1828	65	000		72	-1	19941213	2004010 1	.65			P	01-JAN-00	31-DEC-99
1829	65	000		72	-1	20040102	2004073	.45			P	01-JAN-00	31-DEC-99

SAK DEF PRICE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PROC TYPE	DTE EFFECTIVE	DTE END	PCT DEFAULT	CDE PROC MOD	CDE RATE TYPE	IND METHOD	DTE ACTIVE	DTE INACTIVE
							1						
1830	65	000		72	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1831	65	000		72	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1832	65	000		81	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1833	65	000		81	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1834	65	000		81	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1835	65	000		81	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1836	65	000		99	-1	19941213	20040101	.65			P	01-JAN-00	31-DEC-99
1837	65	000		99	-1	20040102	20040731	.45			P	01-JAN-00	31-DEC-99
1838	65	000		99	-1	20040801	20060731	.65			P	01-JAN-00	31-DEC-99
1839	65	000		99	-1	20060801	22991231	.45			P	01-JAN-00	31-DEC-99
1900	70	000			-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
1950	74	000			3072	19941213	22991231	.65	26	DEF	X	01-JAN-00	31-DEC-99
1951	74	000			3072	19941213	22991231	.65	TC	DEF	X	01-JAN-00	31-DEC-99
2000	74	000		11	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2001	74	000		12	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2002	74	000		13	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2003	74	000		14	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2004	74	000		15	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2005	74	000		20	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2006	74	000		21	-1	19941213	22991231	.5			P	01-JAN-00	31-DEC-99
2007	74	000		22	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2008	74	000		23	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
2009	74	000		24	-1	19941213	22991231	.5			P	01-JAN-00	31-DEC-99
2010	74	000		25	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2011	74	000		26	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2012	74	000		31	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2013	74	000		32	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2014	74	000		33	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2015	74	000		34	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2016	74	000		41	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2017	74	000		42	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2018	74	000		49	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2019	74	000		50	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2020	74	000		51	-1	19941213	22991231	.5			P	01-JAN-00	31-DEC-99
2021	74	000		52	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2022	74	000		53	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2023	74	000		54	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2024	74	000		55	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2025	74	000		56	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2026	74	000		57	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2027	74	000		60	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2028	74	000		61	-1	19941213	22991231	.5			P	01-JAN-00	31-DEC-99
2029	74	000		62	-1	19941213	22991231	.5			P	01-JAN-00	31-DEC-99
2030	74	000		65	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99
2031	74	000		71	-1	19941213	22991231	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
2032	74	000		72	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2033	74	000		81	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2034	74	000		99	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2200	77	000			3072	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2301	77	000		11	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2302	77	000		12	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2303	77	000		13	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2304	77	000		14	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2305	77	000		15	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2306	77	000		20	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2307	77	000		21	-1	19970201	2299123 1	.5			P	01-JAN-00	31-DEC-99
2308	77	000		22	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2309	77	000		23	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2310	77	000		24	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2311	77	000		25	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2312	77	000		26	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2313	77	000		31	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2314	77	000		32	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2315	77	000		33	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2316	77	000		34	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2317	77	000		41	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99
2318	77	000		42	-1	19970201	2299123 1	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
2319	77	000		49	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2320	77	000		50	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2321	77	000		51	-1	19970201	22991231	.5			P	01-JAN-00	31-DEC-99
2322	77	000		52	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2323	77	000		53	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2324	77	000		54	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2325	77	000		55	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2326	77	000		56	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2327	77	000		57	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2328	77	000		60	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2329	77	000		61	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2330	77	000		62	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2331	77	000		65	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2332	77	000		71	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2333	77	000		72	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2334	77	000		81	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2335	77	000		99	-1	19970201	22991231	.65			P	01-JAN-00	31-DEC-99
2400	78	000			3072	19941213	22991231	.4875			P	01-JAN-00	31-DEC-99
2401	78	000			3072	19941213	22991231	.4875	26	DEF	X	01-JAN-00	31-DEC-99
2402	78	000			3072	19941213	22991231	.4875	TC	DEF	X	01-JAN-00	31-DEC-99
2500	78	000		11	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2501	78	000		11	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2502	78	000		12	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRICE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PROC TYPE	DTE EFFECTIVE	DTE END	PCT DEFAULT	CDE PROC MOD	CDE RATE TYPE	IND METHOD	DTE ACTIVE	DTE INACTIVE
							1						
2503	78	000		12	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2504	78	000		13	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2505	78	000		13	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2506	78	000		14	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2507	78	000		14	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2508	78	000		15	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2509	78	000		15	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2510	78	000		20	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2511	78	000		20	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2512	78	000		21	-1	19941213	22991231	.5	26	DEF	M	01-JAN-00	31-DEC-99
2513	78	000		21	-1	19941213	22991231	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2514	78	000		22	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2515	78	000		22	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2516	78	000		23	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2517	78	000		23	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2518	78	000		24	-1	19941213	22991231	.5	26	DEF	M	01-JAN-00	31-DEC-99
2519	78	000		24	-1	19941213	22991231	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2520	78	000		25	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2521	78	000		25	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2522	78	000		26	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2523	78	000		26	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2524	78	000		31	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
2525	78	000		31	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2526	78	000		32	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2527	78	000		32	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2528	78	000		33	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2529	78	000		33	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2530	78	000		34	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2531	78	000		34	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2532	78	000		41	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2533	78	000		41	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2534	78	000		42	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2535	78	000		42	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2536	78	000		49	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2537	78	000		49	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2538	78	000		50	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2539	78	000		50	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2540	78	000		51	-1	19941213	22991231	.5	26	DEF	M	01-JAN-00	31-DEC-99
2541	78	000		51	-1	19941213	22991231	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2542	78	000		52	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2543	78	000		52	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2544	78	000		53	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2545	78	000		53	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2546	78	000		54	-1	19941213	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2547	78	000		54	-1	19941213	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
2548	78	000		55	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2549	78	000		55	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2550	78	000		56	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2551	78	000		56	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2552	78	000		57	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2553	78	000		57	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2554	78	000		60	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2555	78	000		60	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2556	78	000		61	-1	19941213	2299123 1	.5	26	DEF	M	01-JAN-00	31-DEC-99
2557	78	000		61	-1	19941213	2299123 1	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2558	78	000		62	-1	19941213	2299123 1	.5	26	DEF	M	01-JAN-00	31-DEC-99
2559	78	000		62	-1	19941213	2299123 1	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2560	78	000		65	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2561	78	000		65	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2562	78	000		71	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2563	78	000		71	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2564	78	000		72	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2565	78	000		72	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2566	78	000		81	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2567	78	000		81	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2568	78	000		99	-1	19941213	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2569	78	000		99	-1	19941213	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
2700	78	000		11	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2701	78	000		12	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2702	78	000		13	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2703	78	000		14	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2704	78	000		15	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2705	78	000		20	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2706	78	000		21	-1	19941213	2299123 1	.5			P	01-JAN-00	31-DEC-99
2707	78	000		22	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2708	78	000		23	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2709	78	000		24	-1	19941213	2299123 1	.5			P	01-JAN-00	31-DEC-99
2710	78	000		25	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2711	78	000		26	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2712	78	000		31	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2713	78	000		32	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2714	78	000		33	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2715	78	000		34	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2716	78	000		41	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2717	78	000		42	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2718	78	000		49	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2719	78	000		50	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2720	78	000		51	-1	19941213	2299123 1	.5			P	01-JAN-00	31-DEC-99
2721	78	000		52	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2722	78	000		53	-1	19941213	2299123	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
2723	78	000		54	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2724	78	000		55	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2725	78	000		56	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2726	78	000		57	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2727	78	000		60	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2728	78	000		61	-1	19941213	2299123 1	.5			P	01-JAN-00	31-DEC-99
2729	78	000		62	-1	19941213	2299123 1	.5			P	01-JAN-00	31-DEC-99
2730	78	000		65	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2731	78	000		71	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2732	78	000		72	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2733	78	000		81	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2734	78	000		99	-1	19941213	2299123 1	.65			P	01-JAN-00	31-DEC-99
2800	80	000			3072	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
2900	80	000		11	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2901	80	000		11	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2902	80	000		12	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2903	80	000		12	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2904	80	000		13	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2905	80	000		13	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2906	80	000		14	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2907	80	000		14	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2908	80	000		15	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
2909	80	000		15	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2910	80	000		20	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2911	80	000		20	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2912	80	000		21	-1	19970702	2299123 1	.6	26	DEF	M	01-JAN-00	31-DEC-99
2913	80	000		21	-1	19970702	2299123 1	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2914	80	000		22	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2915	80	000		22	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2916	80	000		23	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2917	80	000		23	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2918	80	000		24	-1	19970702	2299123 1	.5	26	DEF	M	01-JAN-00	31-DEC-99
2919	80	000		24	-1	19970702	2299123 1	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2920	80	000		25	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2921	80	000		25	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2922	80	000		26	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2923	80	000		26	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2924	80	000		31	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2925	80	000		31	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2926	80	000		32	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2927	80	000		32	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2928	80	000		33	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2929	80	000		33	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2930	80	000		34	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2931	80	000		34	-1	19970702	2299123	.65	TC	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
2932	80	000		41	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2933	80	000		41	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2934	80	000		42	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2935	80	000		42	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2936	80	000		49	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2937	80	000		49	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2938	80	000		50	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2939	80	000		50	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2940	80	000		51	-1	19970702	2299123 1	.5	26	DEF	M	01-JAN-00	31-DEC-99
2941	80	000		51	-1	19970702	2299123 1	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2942	80	000		52	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2943	80	000		52	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2944	80	000		53	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2945	80	000		53	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2946	80	000		54	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2947	80	000		54	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2948	80	000		55	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2949	80	000		55	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2950	80	000		56	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2951	80	000		56	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2952	80	000		57	-1	19970702	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
2953	80	000		57	-1	19970702	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
2954	80	000		60	-1	19970702	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2955	80	000		60	-1	19970702	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2956	80	000		61	-1	19970702	22991231	.5	26	DEF	M	01-JAN-00	31-DEC-99
2957	80	000		61	-1	19970702	22991231	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2958	80	000		62	-1	19970702	22991231	.5	26	DEF	M	01-JAN-00	31-DEC-99
2959	80	000		62	-1	19970702	22991231	.5	TC	DEF	M	01-JAN-00	31-DEC-99
2960	80	000		65	-1	19970702	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2961	80	000		65	-1	19970702	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2962	80	000		71	-1	19970702	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2963	80	000		71	-1	19970702	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2964	80	000		72	-1	19970702	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2965	80	000		72	-1	19970702	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2966	80	000		81	-1	19970702	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2967	80	000		81	-1	19970702	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
2968	80	000		99	-1	19970702	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
2969	80	000		99	-1	19970702	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3100	80	000		21	-1	19970702	22991231	.5			P	01-JAN-00	31-DEC-99
3101	80	000		24	-1	19970702	22991231	.5			P	01-JAN-00	31-DEC-99
3102	80	000		51	-1	19970702	22991231	.5			P	01-JAN-00	31-DEC-99
3103	80	000		61	-1	19970702	22991231	.5			P	01-JAN-00	31-DEC-99
3104	80	000		62	-1	19970702	22991231	.5			P	01-JAN-00	31-DEC-99
3105	80	000		11	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99
3106	80	000		12	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
3107	80	000		13	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3108	80	000		14	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3109	80	000		15	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3110	80	000		20	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3111	80	000		22	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3112	80	000		23	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3113	80	000		25	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3114	80	000		26	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3115	80	000		31	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3116	80	000		32	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3117	80	000		33	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3118	80	000		34	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3119	80	000		41	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3120	80	000		42	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3121	80	000		49	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3122	80	000		50	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3123	80	000		52	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3124	80	000		53	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3125	80	000		54	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3126	80	000		55	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3127	80	000		56	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99
3128	80	000		57	-1	19970702	2299123 1	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
3129	80	000		60	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99
3130	80	000		65	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99
3131	80	000		71	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99
3132	80	000		72	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99
3133	80	000		81	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99
3134	80	000		99	-1	19970702	22991231	.65			P	01-JAN-00	31-DEC-99
3200	85	000			3072	19000101	22991231	.65	26	DEF	X	01-JAN-00	31-DEC-99
3201	85	000			3072	19000101	22991231	.65	TC	DEF	X	01-JAN-00	31-DEC-99
3300	85	000		11	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3301	85	000		12	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3302	85	000		13	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3303	85	000		14	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3304	85	000		15	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3305	85	000		20	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3306	85	000		21	-1	19000101	22991231	.5	26	DEF	M	01-JAN-00	31-DEC-99
3307	85	000		22	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3308	85	000		23	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3309	85	000		24	-1	19000101	22991231	.5	TC	DEF	M	01-JAN-00	31-DEC-99
3310	85	000		25	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3311	85	000		26	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3312	85	000		31	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3313	85	000		32	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3314	85	000		33	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYPE	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
3315	85	000		34	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3316	85	000		41	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3317	85	000		42	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3318	85	000		49	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3319	85	000		50	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3320	85	000		51	-1	19000101	2299123 1	.5	26	DEF	M	01-JAN-00	31-DEC-99
3321	85	000		52	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3322	85	000		53	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3323	85	000		54	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3324	85	000		55	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3325	85	000		56	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3326	85	000		57	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3327	85	000		60	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3328	85	000		61	-1	19000101	2299123 1	.5	26	DEF	M	01-JAN-00	31-DEC-99
3329	85	000		62	-1	19000101	2299123 1	.5	TC	DEF	M	01-JAN-00	31-DEC-99
3330	85	000		65	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3331	85	000		71	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3332	85	000		72	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3333	85	000		81	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3334	85	000		99	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99
3335	85	000		21	-1	19000101	2299123 1	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3336	85	000		24	-1	19000101	2299123 1	.65	26	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
3337	85	000		51	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3338	85	000		61	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3339	85	000		62	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3340	85	000		11	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3341	85	000		12	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3342	85	000		13	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3343	85	000		14	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3344	85	000		15	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3345	85	000		20	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3346	85	000		22	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3347	85	000		23	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3348	85	000		25	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3349	85	000		26	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3350	85	000		31	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3351	85	000		32	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3352	85	000		33	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3353	85	000		34	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3354	85	000		41	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3355	85	000		42	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3356	85	000		49	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3357	85	000		50	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3358	85	000		52	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3359	85	000		53	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99

SAK DEF PRICE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PROC TYPE	DTE EFFECTIVE	DTE END	PCT DEFAULT	CDE PROC MOD	CDE RATE TYPE	IND METHOD	DTE ACTIVE	DTE INACTIVE
							1						
3360	85	000		54	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3361	85	000		55	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3362	85	000		56	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3363	85	000		57	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3364	85	000		60	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3365	85	000		65	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3366	85	000		71	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3367	85	000		72	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3368	85	000		81	-1	19000101	22991231	.65	26	DEF	M	01-JAN-00	31-DEC-99
3369	85	000		99	-1	19000101	22991231	.65	TC	DEF	M	01-JAN-00	31-DEC-99
3500	85	000		21	-1	19000101	22991231	.5			P	01-JAN-00	31-DEC-99
3501	85	000		24	-1	19000101	22991231	.5			P	01-JAN-00	31-DEC-99
3502	85	000		51	-1	19000101	22991231	.5			P	01-JAN-00	31-DEC-99
3503	85	000		61	-1	19000101	22991231	.5			P	01-JAN-00	31-DEC-99
3504	85	000		62	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3505	85	000		11	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3506	85	000		12	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3507	85	000		13	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3508	85	000		14	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3509	85	000		15	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3510	85	000		20	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3511	85	000		22	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
3512	85	000		23	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3513	85	000		25	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3514	85	000		26	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3515	85	000		31	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3516	85	000		32	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3517	85	000		33	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3518	85	000		34	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3519	85	000		41	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3520	85	000		42	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3521	85	000		49	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3522	85	000		50	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3523	85	000		52	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3524	85	000		53	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3525	85	000		54	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3526	85	000		55	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3527	85	000		56	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3528	85	000		57	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3529	85	000		60	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3530	85	000		65	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3531	85	000		71	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3532	85	000		72	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3533	85	000		81	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99
3534	85	000		99	-1	19000101	22991231	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
							1						
3700	86	000		11	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3701	86	000		12	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3702	86	000		13	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3703	86	000		14	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3704	86	000		15	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3705	86	000		20	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3706	86	000		21	-1	19000101	2299123 1	.5			P	01-JAN-00	31-DEC-99
3707	86	000		22	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3708	86	000		23	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3709	86	000		24	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3710	86	000		25	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3711	86	000		26	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3712	86	000		31	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3713	86	000		32	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3714	86	000		33	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3715	86	000		34	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3716	86	000		41	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3717	86	000		42	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3718	86	000		49	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3719	86	000		50	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3720	86	000		51	-1	19000101	2299123 1	.5			P	01-JAN-00	31-DEC-99
3721	86	000		52	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99

SAK DEF PRI CE	CDE PROV TYPE	CDE PROV SPEC	CDE CLM TYPE	CDE POS	SAK PRO C TYP E	DTE EFFECTI VE	DTE END	PCT DEFAU LT	CDE PROC MOD	CDE RATE TYPE	IND METH OD	DTE ACTIVE	DTE INACTIVE
3722	86	000		53	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3723	86	000		54	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3724	86	000		55	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3725	86	000		56	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3726	86	000		57	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3727	86	000		60	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3728	86	000		61	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3729	86	000		62	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3730	86	000		65	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3731	86	000		71	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3732	86	000		72	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3733	86	000		81	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
3734	86	000		99	-1	19000101	2299123 1	.65			P	01-JAN-00	31-DEC-99
4000	90	000	B		-1	20000101	2299123 1	1			P	01-JAN-00	31-DEC-99
4100	54	000	B		-1	20000101	2299123 1	1			P	01-JAN-00	31-DEC-99

2.18 Member Co-Pay Deduction

2.18.1 Post-Waiver (7/1/2006 – 12/31/2299)

For claims that have a date of service after or on 7/1/2006, the copay logic is rules based. The copay rules are maintained via the panels within [Reference – Benefit Administration – Copay – using the Copay classification].

The user can maintain the rules using many of the same parameters as they can with the reimbursement rules (i.e. effective & end dates, active & inactive dates, age, provider contracts, claim type, etc). NOTE – the member Copay Indicator is not used. It should remain at Both.

The screenshot displays the 'Reference Benefit Administration' web application in Microsoft Internet Explorer. The main content area is titled '100317 for Procedures - All Procedures'. It contains several configuration fields:

- Eff/End Dates:** 07/01/2006 to 12/31/2299
- Act/Inact Dates:** 01/01/1900 to 12/31/2299
- Member Copay Indicator:** Both
- Copay Deduct/Accum:** DA Deduct and accumulate copay
- Copay Amount:** \$3.00
- Age:** 0 to 999999
- Pregnancy Indicator:** Both
- Copay Method:** PDOPD ONCE PER DATE
- Copay Time Period:** CY Calendar Year

Below these fields are three main editing sections:

- Member Plans Editing:** Set to 'Yes'. Includes an 'Options' list with codes like GCMWC, GCECP, CCMWC, CCMB, etc., and a 'Test Claim Value' field.
- Place of Service Editing:** Set to 'No'.
- Claim Type Editing:** Set to 'Include'. Shows 'Claim Types Assigned' (M - PROFESSIONAL CLAIMS, O - OUTPATIENT CLAIMS) and 'Available Claim Types' (0 - ALL CLAIM TYPES, A - INST XOVER CLAIMS, B - PROF XOVER CLAIMS, C - QUTP XOVER CLAIMS, D - DENTAL CLAIMS, H - HOME HEALTH CLAIMS).

There is an annual (calendar year based) out-of-pocket maximum, of copay and coinsurance, of \$225.00 for each member.

Maximum out-of-pocket – calendar year 2007 - \$225.00.

Maximum out-of-pocket – calendar year 2006 - \$112.50.

Once this threshold (Maximum out-of-pocket) is met, no additional deductions for copay or coinsurance are taken for that calendar year.

In the post-waiver, a copay can be either a deduct and accumulate or an only accumulate.

- The deduct and accumulate copays for services will be deducted from the claim and accumulated towards the member’s annual out-of-pocket maximum.
- The only accumulate copays for services will not be deducted from the claim, but it will be accumulated towards the member’s annual out-of-pocket maximum.

The user can select the copay method and the dollar amount of the copay to be applied to the claim. The Bypass copay processing is used for pregnancy diagnosis codes. If one of these diagnosis codes is found on the claim, copay will not be taken (deduct and accumulate or only accumulate) for the claim.

Copay will be deducted only once per date of service for each member/provider combination. In other words, if a member receives more than one service on a particular date from the same provider, only one co-pay will be deducted for that date of service. If a member sees two different providers on the same date, copay will be deducted from both claims.

2.18.2 Case Cost Share (10/1/2008 – 12/31/2299)

For claims that have paid date on or after 10/1/2008, the case cost share is calculated to determine when a case has met 5% maximum out of pocket expenses of the case quarterly income (calendar quarters are January – March, April – June, July – September, and October – December). Out of pocket expenses calculated for cost share include member coinsurance, member copay (calculated from paid claims), individual member premiums for Medicaid works members, and case premiums (\$20.00 per month for case with member with P7 status code and \$30.00 per month for TMA members in last 6 months of coverage). The Case Cost Share is displayed via the panels within [Member – Case – Cost Share].

The screenshot shows the 'Case Cost Share' section of the website. It includes a table with the following data:

Quarter	Income	Case Premium	Out Of Pocket	Income Used(%)	Cost Share Indicator
4 [Oct-Dec]	\$636.00	\$0.00	\$2	0.31	N

Below the table is a 'Member List' section with the following data:

Member ID	First Name	Last Name	Pharmacy Copay	Medical Copay	Medical Co-Insurance	Individual Premium Paid
999999999	AMELIA	JONES				
4 [Oct-Dec]			\$0.00	\$2.00	\$0.00	\$0.00

Once this threshold (Maximum out-of-pocket) is met, no additional deductions for copay or coinsurance are taken for **any** member in the case for the remainder of that calendar quarter.

If case has zero income, the cost share indicator is set to ‘Y’ to indicate cost share has been met. No copay or coinsurance deductions will be taken for any member in that case for the remainder of the calendar quarter.

If cost share has not been met for a case, but an individual case member has met their annual copay/coinsurance maximum, no copay or coinsurance will be deducted for that individual for the remaining calendar year. However, cost share will still be accumulated for the rest of the case until 5% threshold has been met for the calendar quarter.

If cost share has not been met for a case, then normal copay and coinsurance rules apply for individual case members.

2.18.3 Copay/Coinsurance Panels (post-waiver)

Every claim for a member (post-waiver) allows the user to access information regarding copay/coinsurance accumulation. The panels are accessed via claim navigation, but do show all accumulated data for the member.

2.18.3.1 Member Copay Panel

Member Copay								
Header/Detail Number	Financial Payer	Year Month Date	Status	Copay Value	Copay Amount	FDOS	TDOS	
0	DEF	0	Active	Deduct and Accumulate	\$15.00	03/01/2005	03/01/2005	
1	DEF	0	Active	Deduct and Accumulate	\$30.00	03/02/2005	03/02/2005	

2.18.3.2 Member Coinsurance Panel

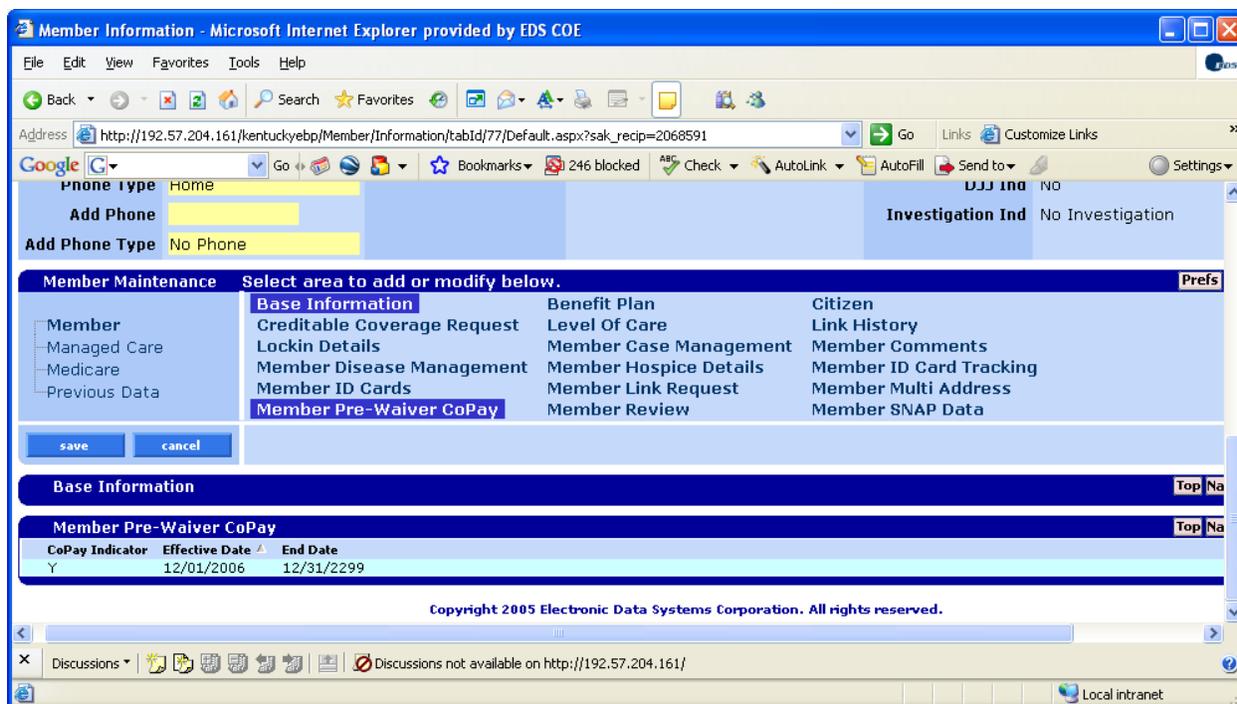
Member Coinsurance							
Header/Detail Number	Financial Payer	Year Month Date	Status	Coinsurance Amount	FDOS	TDOS	
0	DEF	0	Active	\$10.00	03/01/2005	03/01/2005	
1	DEF	0	Active	\$20.00	03/02/2005	03/02/2005	

2.18.4 Pre-Waiver (Prior to 7/1/2006)

For claims that have a date of service prior to 7/1/2006, the copay logic is not rules based. One of the main drivers in determining if a member has copay applied is the member’s copay indicator which can be found on the Member Pre-Waiver CoPay panel (Member subsystem).

If this value is ‘N’ (No), no copay is taken from the claim.

If ‘Y’ (Yes), copay may be taken depending on other exclusions.



Exclusions

Exclude copay from being taken from the claim regardless of claim type.

- Copay will **not** be deducted if the member \ status code is P5, P6 or P7 and the procedure code is: 09110, 00140 D0150, D0210, D0220, D0230, D0270, D0272, D0274, D0330, D0340, D1110, D1201, D1351, D1510, D1515, D1520, D1525 or D1550.
 - Procedure codes are maintained in procedure groups
 - 3090 (KY Proc Code Copay Exemption 1)
 - 3091 (KY Proc Codes Copay Exemption 2 KCHIP)
- Copay will **not** be deducted if the member is in the Presumptive Eligibility (PE) benefit plan for the date of service.
- Copay will **not** be deducted if the member status code is P2 or P3.
- Copay will **not** be deducted if the member has a program code of U, P, S, or X and the member is under age 19.
- Copay will **not** be deducted if the claim has a pregnancy diagnosis code on the claim.

Medical and Dental claims (additional exclusions and other info)

Additional Exclusions

- Co-pay will **not** be deducted from details with the following place of service codes:

- 31 – Skilled Nursing Facility
- 32 - Nursing Facility
- 33 - Custodial Care Facility
- 54 - Intermediate Care Facility/Mentally Retarded
- Co-pay will **not** be deducted if the member is under age 19.
- Co-pay will **not** be deducted if the member has a Hospice benefit plan that covers the date of service.

Other Info

- Copay is \$2.00, subtracted at the detail from the claim.
- Copay will be deducted only once per date of service for each member/provider combination. In other words, if a member receives more than one service on a particular date from the same provider, only one copay will be deducted for that date of service. If a member sees two different providers on the same date, copay will be deducted from both claims. In cases where a member receives services from a clinic, co-pay will be deducted only once per date, **per clinic**, even though the member may have received services by different providers within the clinic.
- Co-pay will **not** be deducted if the member is under age 18 or if the date of service is in the month of the member's 18th birthday.
 - Dental/PT 60, 61 - all procedures with the exception of 09110 and 00140. and Well-baby/Well-child Preventative Dental Services for KCHIIP Members.
- Optometry/PT 77 - all procedures prior to 12/01/03. For claims with date of service on and after 12/01/03 co-pay is deducted from procedure codes 92002, 92004, 92012 and 92014.
- Optician/PT 52 - all procedures
- Audiology/PT 70 - all procedures
- Hearing Aid/PT 50 - all procedures
- Chiropractor/PT 85 - all procedures
- Podiatry/PT 80 - all procedures
- Physician/PT 64, 65 - procedure codes 92002, 92004, 92012, 92014
- ARNP/PT 78 - procedure codes 92002, 92004, 92012, 92014
- Primary Care/PT 31 - procedure codes 92002, 92004, 92012, 92014
- Rural Health/PT 35 - procedure codes 92002, 92004, 92012, 92014

Inpatient & Outpatient claims (additional exclusions and other info)

Additional Exclusions

- For inpatient and outpatient hospital claims co-pay will not be deducted when the following ICD-9 diagnosis code(s) is present on the claim: 630 through 633, 640 through 645, 650 through 659, and 660 through 669.
 - Diagnosis codes are maintained in diagnosis group
 - 1027 (KY Diag Codes for pre KY copay exemptions)
- Copay will not be deducted from inpatient or outpatient crossovers.
- The 3.00 outpatient co-pay will NOT be deducted from claims that have emergency room revenue code 450 or 456.

Other Info

- Copay will be deducted from Inpatient and Outpatient hospital (prov type 01), Psychiatric Distinct part Unit (prov type 92) and Rehabilitation Distinct part Unit (prov type 93) claims.
- Copay is \$3.00, for outpatient claims, subtracted at the detail from the claim.
- Copay is \$50.00, for inpatient claims, subtracted at the header from the claim.
- Copay will be deducted only once per date of service for each member/provider combination. In other words, if a member receives more than one service on a particular date from the same provider, only one copay will be deducted for that date of service. If a member sees two different providers on the same date, copay will be deducted from both claims. In cases where a member receives services from a clinic, co-pay will be deducted only once per date, **per clinic**, even though the member may have received services by different providers within the clinic.

2.19 Coinsurance

Coinsurance has been implemented for the post-waiver (7/1/2006 – 12/31/2299).

Emergency room coinsurance will be taken for service code 99281 (procedure code).

Coinsurance will be calculated as 5% of the allowed amount.

DME coinsurance will be a maximum of \$15.00 in a calendar month.

DME coinsurance will be calculated as 3% of the allowed amount.

Some DME services are excluded from DME coinsurance. These are maintained in the procedure group 3097 (KY Proc Codes Coinsurance Bypass for DME). These can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).

Exclusions for coinsurance are coded within the claims engine. Exclusions for coinsurance include pregnancy diagnosis codes, and certain DME services (i.e. Procedure Group 3097 - KY Proc Codes Coinsurance Bypass for DME).

2.20 Member Spenddown Deduction

The member spenddown amount will be subtracted at the header for institutional claims and at the detail for all other claims. If the spenddown date is equal to or within the from and to dates of service on the claim spenddown is deducted. Spenddown is **not applied** to crossover, waiver or claims submitted by the following claim/provider types:

Provider Types: 02, 04,17, 33, 41, 42, 43, 46, 47

Spenddown may be deducted from multiple claims if the member is spenddown for the dates of service being billed and if there is a remaining balance to be deducted. Once the spenddown amount for that date has been met the balance will become zero (0) and no further deductions will be made.

Claims that have had the spenddown deduction applied will receive an appropriate EOB for spenddown.

Spenddown is maintained in the Member subsystem.

2.21 Encounter Pricing

Professional, Institutional and Dental encounters will be reimbursed as if they were fee-for-service claims. The price is stored and presented as the Allowed Amount. The Allowed Amount for the encounter is calculated the same way the Allowed Amount is calculated for a fee-for-service claim. Encounters will go through the editing, auditing and benefit plans as a normal claim.

Pharmacy encounters are not priced at this time. The policy needed to price pharmacy claims is not implemented and maintained in interchange.

anonymous user [window 2] Thursday, July 02, 2009
KyHealth Choices Click Here To Open New Window

Home Claims Reference Provider **Member** Financial EPSDT TPL Managed Care MAR Prior Authorization CTMS Security Site Admin Host

search information add pending **case** other IDs case mgmt disease mgmt service usage EDB Search related data reports

Case Information

Case Number 0000000000 Name MEMBER, NAME A
Worker ID Income Amount \$1,000.00 Member IDs/Certification Dates 0000000000 - 08/08/2007

Case Maintenance Select area to add or modify below. Prefs Top Bot

Base Information Case Cost Share Case Members
Case Spenddown Case Yearly Accumulations

Base Information Top Nav A X

Case Spenddown Top Nav A X

Amount	Time Period Indicator	Financial Payer	Provider Number	Effective Date	End Date
\$1,100.00	S	1 Default		05/01/2007	06/30/2007
\$2,300.00	S	1 Default		07/01/2007	09/30/2007
\$2,100.00	S	1 Default		01/07/2008	03/31/2008
\$2,200.00	S	1 Default		04/30/2008	06/30/2008
\$2,200.00	S	1 Default		07/14/2008	09/30/2008

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

Amount Effective Date
Time Period Indicator End Date
Financial Payer
Provider Number [Search]

delete add

3 “OTHER INSURANCE” Deduction

Third party liability amounts (also called “other insurance”) entered on the claim form is subtracted from the Medicaid allowed amount to determine Medicaid reimbursement. If the TPL amount equals or exceeds the Medicaid allowed amount the claim will pay zero.

NOTE:

For claims paid at the detail, the header TPL amount is applied to each detail in descending order until the total TPL amount is exhausted. For example, if claimed has a TPL amount of \$50.00 and two details, each with Medicaid allowed amount of \$30.00, the TPL amount would be applied as follows:

- a. The Medicaid reimbursement amount of the 1st detail would be zero.
- b. The Medicaid reimbursement amount of the 2nd detail would be \$10.00 [\$30.00 (allowed amount) minus \$20.00 (difference between TPL amount and allowed amount of the 1st detail)].

3.1 Patient Liability – Institutional Claims (Psychiatric Hospital, Nursing Facility, PRTF)

Patient liability (also referred to as “continuing income”) amounts for waiver members are maintained on the Member Patient Liability panel.

The patient liability amount listed on Member Patient Liability panel is a monthly amount. If the claim is billed for a full month (i. e. 1/1/07 through 1/31/07), the entire patient liability amount is subtracted. If the claim is billed for less than a one month period, the patient liability amount must be prorated. To determine the prorated amount, multiply the Patient Liability amount by the number of covered days and divide the product (of Patient Liability * Covered Days) by the number of days in the month being billed. For example, the prorated patient liability on a claim being billed for 15 days in June would be computed as follows (assume a monthly patient liability amount of \$100.00):

$$\begin{array}{r}
 \$100.00 \text{ (Monthly Patient Liability Amount)} \\
 \times \quad 15 \text{ (Covered Days)} \\
 \div \quad 30 \text{ (Number of Days in June)} \\
 = \quad \$50.00 \text{ (Prorated Patient Liability)}
 \end{array}$$

Patient liability is not deducted on Mental Hospital claims if the member is QMB.

Patient liability is not deducted from Psychiatric Hospital claims for days a member is in Psychiatric Resident Treatment Facility (PRTF) bed reserve status.

Patient liability is not deducted from crossover claims if the member is QMB-only (Member Program Code = Z_) or dually eligible (Member Status Code = double alpha/AA, BB, CC, etc.).

Patient Liability is maintained in the Member subsystem.

Member Information - Microsoft Internet Explorer provided by EDS COE

Address: http://192.57.204.161/kentuckyebp/Member/Information/tabId/77/Default.aspx?sak_recip=2069602

Phone Type: No Phone
Add Phone: [Field]
Add Phone Type: No Phone

DJJ Ind: No
Investigation Ind: No Investigation

Member Maintenance Select area to add or modify below.

Member	Base Information	Benefit Plan	Citizen
Managed Care	Creditable Coverage Request	Level Of Care	Link History
Medicare	Lockin Details	Member Case Management	Member Comments
Previous Data	Member Disease Management	Member Hospice Details	Member ID Card Tracking
	Member ID Cards	Member Link Request	Member Multi Address
	Member Pre-Waiver CoPay	Member Review	Member SNAP Data

save cancel

Base Information Top Nav

Patient Liability Top Nav

Monthly Amount	Type	Effective Date	End Date
\$725.00	Hospice	01/19/2007	01/25/2007
\$725.00	LTC	12/01/2006	01/18/2007
\$0.00	Continued Zero Liability for Nursing Facility	11/22/2006	11/30/2006

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

Monthly Amount: [Field]
Effective Date: [Field]
Type: [Dropdown]
End Date: [Field]

delete

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Local intranet

3.2 Patient Liability – Waiver Claims (ADC, HCB, Brain injury, Supports for Community Living, Model Waiver 2, Home Care Waiver, Personal Care Waiver)

Patient liability (also referred to as “continuing income”) amounts for waiver members are maintained on the Member Patient Liability panel.

On the first day of each month a waiver patient liability segment for that month is systematically added for each member with waiver eligibility for that month. As waiver claims with dates of service for that month are processed and approved for payment, the patient liability amount is decreased by the Medicaid allowed amount of each claim until the patient liability amount is zero. This results in waiver claims **paying zero** until the patient liability amount for that month is exhausted.

For example, if the member’s patient liability amount for March is \$200 and the first waiver claim with March dates of service is approved for payment with an allowed amount of \$50, the claim will pay zero and the March patient liability **balance** will be decreased to \$150. If a second March claim is approved for payment with an allowed of \$80, that claim will also pay zero and the March patient liability amount will be decreased to \$70. Claims with March dates of service will continue to pay zero until the patient liability balance is zero. After the balance reaches zero, all subsequent claims with March dates of service will pay whatever amount is approved.

If the patient liability balance is less than the Medicaid allowed amount, the balance will be subtracted from the allowed amount and Medicaid reimbursement will be the difference of the two (Allowed Amount minus Patient Liability Balance = Medicaid Reimbursement Amount).

Patient Liability is maintained in the Member subsystem.

Note – For SCL (provider type 33) claims for members other than those with Michelle P and ABI LTC assignment plans no patient liability is deducted for procedure codes T2021 or H2021. Also, per CO 8834, no patient liability is deducted for procedure codes T1005, H0039, H0004, 90804, 97530, 92507, 97110, 97535, 97537, E1399, H0002, H0032.

For SCL claims for members other than those with Michelle P and ABI LTC assignment plans with procedure codes T2022 and X0076, patient liability is only deducted if the member DOES NOT have a prior authorization for procedure codes T2016, H0043, S5126, S5140, X0061, X0088, X0089 and X0103 for a provider number DIFFERENT than the one on the T2022/X0076 claim. Only PAs for time frames that encompass the T2022/X0076 date of service will be considered. If there is a PA for one of these 8 procedure codes for a SCL provider different than the billing provider, patient liability will not be deducted from the payment for T2022 or X0076.

For SCL claims for Michelle P and ABI LTC Waiver members patient liability is deducted from all procedure codes if the claim is submitted by the member's case manager (found on the member Waiver details panel).

Note – For Home and Community based claims (PT 42) for members other than those with Michelle P and ABI LTC assignment plans patient liability is only deducted if the member has a Waiver Code of 'B' (HCBS Waiver).

For HCB claims for MFP, Michelle P, and ABI LTC Waiver members patient liability is deducted only if the claim is submitted by the member's case manager/primary provider (found on the member Waiver details panel).

Note - For Adult Day Care (provider type 43) claims processed after 11/30/2011 (CO 16780) patient liability is only deducted if the claim is submitted by the member's case manager/primary provider (found on the member Waiver details panel). For Adult Day Care claims processed prior to 12/01/2011, the member's case manager/primary provider number was only considered for Michelle P, ABI/LTC, and MFP member claims.

Note - For Acquired Brain Injury (provider type 17) claims, including ABI LTC, patient liability is deducted from all procedure codes if the claim is submitted by the member's primary provider (found on the member Waiver details panel).

Note – for SCL, ABI, and ADC CDO claims with dates of service prior to 07/01/2008 patient liability is NOT deducted. For dates of service of 07/01/2008 and after patient liability is only deducted from procedure code T2022 for CDO claims.

4 Claim Type Pricing Grids

4.1 Reading the Pricing Grids

To “price” a claim, the user must know the claim type (alpha character) and the provider type. Using this information, the logic the claim used to price is organized in a grid as shown below.

1.1 Claim Type M: EPSDT–Related Services (Prov Type 45)			
Alpha Claim Type	M (formerly Legacy K)	Provider Type	45
Provider Contract	EPSPS	Reimbursement Classification	Standard
Methodology/Logic	EPSDT–Related Services will price using the pricing method: LPABIL (Lesser of PA or Bill Amt) Pricing Method(s): Services will have a "Y" PA indicator on the provider contract for the provider (EPSDT-Related Services). The LPABIL pricing method will be used. This compares the PA amount versus the Max Fee for the service (i.e. procedure code). The reimbursement is determined by comparing the detail billed amount to the prior authorized amount listed on the Prior Authorization file. The reimbursement is the lesser of the two (less other insurance and <u>spenddown</u> , if any). Default Pricing Logic: None Pricing Method - Services which Require PA: None Additional Reimbursement Info: None		
Exceptions	There are no exceptions.		

Field	Description
Alpha Claim Type	Lists the alpha character claim type to which the methodology applies.
Provider Type	Lists the two-digit numeric provider types to which the methodology applies.
Provider Contract	Lists the applicable Provider Contract. Users with Benefits Administration access may view the Provider Contract.
Reimbursement Classification	Lists the applicable Reimbursement Classification. Users with Benefits Administration access may view the Reimbursement Classification and associated Reimbursement Rules.
Methodology/Logic	This section explains the process by which the claim is “priced.” The name of the method is listed and a description of the method. The description will detail what panels a user should reference when verifying a claim’s price.

Field	Description
Default Pricing Logic	Default pricing logic is applied when other logic does not exist.
Pricing Method- Services which Require PA	Describes pricing methodology for services which MUST have a PA to price. This does not indicate whether or a not service must have a PA; only if the pricing logic depends on PA.
Additional Reimbursement Info	Additional information about pricing (reductions, special logic) appears here.
Exceptions	Exceptions to the logic listed above will be listed here. Exceptions would include claims with certain procedure codes or particular providers.

4.2 Claim Type A

4.2.1 Claim Type A: Hospital (Inpatient) Crossover – Part B (Prov Type 01)

Alpha Claim Type	A (formerly Legacy V)	Provider Type	01
Provider Contract	HOSP NACIP	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Pricing Method: Part B Inpatient Hospital, Rehabilitation DPU, and Psychiatric DPU Crossover claims pay 100% of the header coinsurance, plus the header deductible as listed on the claim form (less other insurance, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.2.2 Claim Type A: Inpatient Hospital (Prov Type 01) Part A Crossover

Alpha Claim Type	A (formerly Legacy V)	Provider Type	01
Provider Contract	HOSP NACIP	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Pricing Method: Inpatient Hospital, Rehabilitation DPU, and Psychiatric DPU Part A crossovers have a type of bill of 111, 112, 113, or 114. For claims with DOS after 8/31/02 reimbursement is determined by calculating the <i>regular</i> Medicaid allowed amount then comparing the regular Medicaid allowed amount to the Medicare paid amount.</p> <p>If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p>		

	Additional Reimbursement Info: None
Exceptions	There are no exceptions.
Examples	<p><u>Example 1:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 1200.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount-claim pays zero)</p> <p><u>Example 2:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 100.00</p> <p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 300.00</p> <p><u>Example 3:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 812.00</p> <p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 379.03</p> <p>Inpatient Hospital Part A Crossover claims with dates of service <u>prior to 09/01/02</u> pay 100% of the header coinsurance and deductible (less other insurance, if any).</p>

4.2.3 Claim Type A: Mental Hospital Crossover – Part B (Prov Type 02)

Alpha Claim Type	A (formerly Legacy V)	Provider Type	02
Provider Contract	MENTH	Reimbursement Classification	RC Psych Hospital

Methodology/Logic	<p>Pricing Method:</p> <p>Part B Mental Hospital Part B Crossover claims pay 100% of the header coinsurance, plus the header deductible as listed on the claim (less other insurance, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.2.4 Claim Type A: Mental Hospital (Prov Type 02) Part A Crossover

Alpha Claim Type	A (formerly Legacy V)	Provider Type	02
Provider Contract	MENTH	Reimbursement Classification	RC Psych Hospital
Methodology/Logic	<p>Mental Hospital Crossover claims will price using the pricing method:</p> <p>LT1918 Crossover pricing is used for Mental Hospital crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Mental Hospital Part A crossovers have a type of bill of 111, 112, 113, or 114.</p>		
Exceptions	There are no exceptions.		
Examples	<u>Example 1:</u>		

	<p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 1200.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount-claim pays zero)</p> <p><u>Example 2:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 100.00</p> <p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 300.00</p> <p><u>Example 3:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 812.00</p> <p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 379.03</p>
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4.2.5 Claim Type A: Mental Hospital Crossover – Part A (Prov Type 02)

Alpha Claim Type	A (formerly Legacy V)	Provider Type	02
Provider Contract	MENTH	Reimbursement Classification	RC Psych Hospital
Methodology/Logic	<p>Pricing Method:</p> <p>Mental Hospital Part A* Crossover claims pay 100% of the header coinsurance, plus the header deductible (less other insurance and patient liability**, if any).</p> <p style="text-align: center;">*Part A – Type of Bill 111, 112, 113, 114</p> <p>**The Patient Liability amount listed on the Member Eligibility File is a monthly amount. If the claim is billed for less than a one (1) month period, the liability amount must be pro-rated. To determine the pro-rated amount, multiply the liability amount by the number of days in the month for which the claim is being billed. Then divide this amount (liability</p>		

	<p>amount x number of days in month) by the number of covered days.</p> <p>NOTE: For claims with dates of service after 10/31/92, the liability amount is not deducted if the member has a QMB segment on the Member Eligibility File with a QMB indicator of “A” for the header from date of service.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.2.6 Claim Type A: Case Mix/Nursing Facility Crossover – Part A (Prov Type 12)

Alpha Claim Type	A (formerly Legacy X)	Provider Type	12
Provider Contract	NF	Reimbursement Classification	RC Nursing Facility
Methodology/Logic	<p>Pricing Method:</p> <p>Part A* Case Mix Crossover pay 100% of the header deductible, plus the header coinsurance amount as listed on the claim form (less Patient Liability** and Other Insurance, if any).</p> <p>*Part A – Type of Bill 811, 812, 813, 814</p> <p>**The Patient Liability amount listed on the Member Eligibility File is a monthly amount. If the claim is billed for less than a one (1) month period, the liability amount must be pro-rated. To determine the pro-rated amount, multiply the liability amount by the number of days in the month for which the claim is being billed. Then divide this amount (liability amount x number of days in month) by the number of covered days.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.2.7 Claim Type A: Case Mix/Nursing Facility Part A Crossover (Prov Type 12)

Alpha Claim Type	A (formerly Legacy X)	Provider Type	12
Provider Contract	NF	Reimbursement Classification	RC Nursing Facility
Methodology/Logic	<p>Part A Nursing Facility crossovers have a type of bill of 811, 812, 813, or 814. For DOS after 8/31/02 Medicaid reimbursement is determined by calculating a <i>regular</i> Medicaid allowed amount and comparing this amount to the Medicare paid amount. Please see the following two formulas. Please note ventilator Nursing Facility providers 12502217 and 12503249 pay using the Mode 03 rate.</p> <p>A. When Covered Days and Coinsurance Days are the same:</p> <p>Compare Medicare Paid Amount to regular Medicaid Allowed Amount (Mode 01 Rate X Coinsurance Days)</p> <p>If Medicare Paid Amount is equal to or greater than the regular Medicaid Allowed Amount, the claim will pay zero.</p> <p>If Medicare Paid Amount is less than the regular Medicaid Allowed Amount, reimbursement will be the difference up to the total of coinsurance plus deductible (less patient liability and TPL, if any).</p> <p>Difference of regular Medicaid Allowed Amount (\$3150.00) minus Medicare Paid Amount (\$2500.00) equals \$650.00. Since this is less than the coinsurance plus deductible (\$3045.00), Medicaid reimbursement is \$650.00</p>		
Exceptions	There are no exceptions.		
Examples	<p><u>Example 1</u></p> <p>Covered Days = 30</p> <p>Coinsurance Days = 30</p> <p>Medicare Paid = \$4500.00</p> <p>Coinsurance = \$3045.00</p> <p>Patient Liability = 0</p> <p>TPL = 0</p> <p>Mode 01 Rate = \$105.00</p> <p>Regular Medicaid Allowed Amount (\$105.00 X 30) = \$3150.00</p> <p>Medicare Paid Amount is greater than regular Medicaid Allowable – claim pays zero</p>		

Example 2

Covered Days = 30

Coinsurance Days = 30

Medicare Paid = \$2500.00

Coinsurance \$3045.00

Patient Liability = 0

TPL = 0

Mode 01 Rate = \$105.00

Regular Medicaid Allowed Amount ($\$105.00 \times 30$) = \$3150.00**Example 3**

Covered Days = 30

Coinsurance Days = 30

Medicare Paid = \$800.00

Coinsurance \$3045.00

Patient Liability = 0

TPL = 0

Mode 01 Rate = \$130.00

Regular Medicaid Allowed Amount ($\$130.00 \times 30$) = \$3900.00

Difference of regular Medicaid Allowed Amount (\$3900.00) minus Medicare Paid Amount (\$800.00) equals \$3100.00. Since difference is greater than the coinsurance plus deductible, Medicaid reimbursement is \$3045.00.

B. When Covered Days and Coinsurance Days are not equal:***Step #1:***

Determine Medicare Rate:

$$\frac{(\text{Medicare Paid Amount} + \text{Coinsurance}) \text{ Divided by Covered Days} = \text{Medicare Rate}}$$

Step #2:

Determine Days fully Paid by Medicare

$$\text{Covered Days} - \text{Coinsurance Days} = \text{Days fully covered by Medicare}$$

	<p>Step #3:</p> <p>Determine amount Medicare paid for Fully Covered Days (Step #2)</p> $\text{Medicare Rate (Step \#1)} \times \text{Fully Covered Days (Step\# 2)} =$ <p style="text-align: center;">Amount paid by Medicare for fully covered days</p> <p>Step #4:</p> <p>Apply amount paid for fully covered Medicare days by subtracting product determined under Step #3 from Amount Paid by Medicare.</p> <p>Step # 5</p> <p>Determine regular Medicaid Allowed Amount:</p> $\text{Mode 01 Rate} \times \text{Coins Days} = \text{Regular Medicaid Allowed Amount}$ <p>Step # 6</p> <p>Compare amount determined under Step #4 to Regular Medicaid allowable (Step 5).</p> <p>If the Medicare paid amount under Step #4 is equal to or greater than the regular Medicaid Allowed Amount, the claim will pay zero.</p> <p>If Medicare Paid Amount under step #4 is less than the regular Medicaid Allowed Amount, reimbursement will be the difference up to the total of coinsurance plus deductible (less patient liability and TPL, if any).</p> <p><u>Example 1</u></p> <p>Covered Days = 31</p> <p>Coinsurance Days = 27</p> <p>Coinsurance = \$2673.00</p> <p>Deductible = 0</p> <p>Medicare Paid Amount = \$7671.08</p> <p>Mode 01 Rate = \$105.00</p> <p>Step #1:</p> <p>Determine Medicare Rate:</p> <p>Add: Medicare Paid Amount: \$7671.08</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Coinsurance</td> <td style="text-align: right; width: 20%;"><u>2673.00</u></td> <td style="width: 20%;"></td> </tr> <tr> <td></td> <td style="text-align: right;">\$10,344.08</td> <td></td> </tr> <tr> <td style="text-align: center;">Divided by Coinsurance Days</td> <td></td> <td style="text-align: right;">/31 = \$333.68</td> </tr> </table>	Coinsurance	<u>2673.00</u>			\$10,344.08		Divided by Coinsurance Days		/31 = \$333.68
Coinsurance	<u>2673.00</u>									
	\$10,344.08									
Divided by Coinsurance Days		/31 = \$333.68								

	<p>Step #2:</p> <p>Subtract :</p> <table style="margin-left: 40px;"> <tr> <td>Covered Days</td> <td style="text-align: right;">31</td> </tr> <tr> <td>Coinsurance Days</td> <td style="text-align: right;"><u>-27</u></td> </tr> <tr> <td>Days fully covered by Medicare</td> <td style="text-align: right;">4</td> </tr> </table> <p>Step #3:</p> <p>Determine amount Medicare paid for days determined under Step #2 by multiplying Medicare Rate by Fully Covered Days</p> <p>$\\$333.68 \times 4 = \\1334.72</p> <p>Step #4:</p> <p>Apply amount paid for fully covered Medicare days by subtracting product determined under Step #3 from Amount Paid by Medicare.</p> <table style="margin-left: 40px;"> <tr> <td style="text-align: right;">\$7671.08</td> </tr> <tr> <td style="text-align: right;"><u>- 1334.72</u></td> </tr> <tr> <td style="text-align: right;">\$6336.36 (Amount Medicare paid for 27 coinsurance days)</td> </tr> </table> <p>Step # 5</p> <p>Determine Regular Medicaid Allowed Amount:</p> <p style="margin-left: 40px;">$\\$105.00$ (Mode 01 Rate) X 27 (Coinsurance Days) = \$2835.00</p> <p>Step # 6</p> <p>Compare amount determined under Step #4 (\$6,336.36) to Regular Medicaid Allowed Amount (\$2835.00).</p> <p>Since the Medicare paid amount under Step #4 is greater than the Regular Medicaid Allowed Amount, reimbursement is zero.</p> <p><u>Example 2</u></p> <p>Covered Days = 31</p> <p>Coinsurance Days = 27</p> <p>Coinsurance = \$2673.00</p> <p>Deductible = 0</p> <p>Medicare Paid Amount = \$3000.00</p> <p>Mode 01 Rate = \$105.00</p>	Covered Days	31	Coinsurance Days	<u>-27</u>	Days fully covered by Medicare	4	\$7671.08	<u>- 1334.72</u>	\$6336.36 (Amount Medicare paid for 27 coinsurance days)
Covered Days	31									
Coinsurance Days	<u>-27</u>									
Days fully covered by Medicare	4									
\$7671.08										
<u>- 1334.72</u>										
\$6336.36 (Amount Medicare paid for 27 coinsurance days)										

	<p>Patient Liability = \$100.00</p> <p>Step #1:</p> <p>Determine Medicare Rate:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Add:</td> <td style="width: 55%;">Medicare Paid Amount</td> <td style="width: 30%; text-align: right;">\$3000.00</td> </tr> <tr> <td></td> <td>+ Coinsurance</td> <td style="text-align: right;"><u>+2673.00</u></td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;">\$5673.00</td> </tr> <tr> <td></td> <td>Divided by Coinsurance Days</td> <td style="text-align: right;">/31 = \$183.00</td> </tr> </table> <p>Step #2:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Subtract :</td> <td style="width: 55%;">Covered Days</td> <td style="width: 30%; text-align: right;">31</td> </tr> <tr> <td></td> <td>Coinsurance Days</td> <td style="text-align: right;"><u>-27</u></td> </tr> <tr> <td></td> <td>Days fully covered by Medicare</td> <td style="text-align: right;">4</td> </tr> </table> <p>Step #3:</p> <p>Determine amount Medicare paid for days determined under Step #2 by multiplying Medicare Rate by Fully Covered Days</p> <p style="text-align: center;">\$183.00 X 4 = \$732.00</p> <p>Step #4:</p> <p>Apply amount paid for fully covered Medicare days by subtracting product determined under Step #3 from Amount Paid by Medicare.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 55%;"></td> <td style="width: 30%; text-align: right;">\$3000.00</td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;"><u>- 732.00</u></td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;">\$2268.00 (Amount Medicare paid for 27 coinsurance days)</td> </tr> </table> <p>Step # 5</p> <p>Determine Regular Medicaid Allowed Amount:</p> <p style="text-align: center;">\$105.00 (Mode 01 Rate) X 27 (Coinsurance Days) = \$2835.00</p> <p>Step # 6</p> <p>Compare amount determined under Step #4 (\$2268.00) to Regular Medicaid Allowed Amount (\$2835.00).</p> <p>Medicaid reimbursement is \$467.00 [(Regular Medicaid Allowed Amount – Step# 4 Amount) - Patient Liability].</p>	Add:	Medicare Paid Amount	\$3000.00		+ Coinsurance	<u>+2673.00</u>			\$5673.00		Divided by Coinsurance Days	/31 = \$183.00	Subtract :	Covered Days	31		Coinsurance Days	<u>-27</u>		Days fully covered by Medicare	4			\$3000.00			<u>- 732.00</u>			\$2268.00 (Amount Medicare paid for 27 coinsurance days)
Add:	Medicare Paid Amount	\$3000.00																													
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		<u>- 732.00</u>																													
		\$2268.00 (Amount Medicare paid for 27 coinsurance days)																													

4.2.8 Claim Type A: Case Mix/ Nursing Facility Crossover – Part B (Prov Type 12)

Alpha Claim Type	A (formerly Legacy X)	Provider Type	12
Provider Contract	NF NFCB (Cost Based)	Reimbursement Classification	RC Nursing Facility
Methodology/Logic	<p>Case Mix / Nursing Facility Crossover claims will price using the pricing method:</p> <p>LT1918 Crossover pricing is used for Case Mix / Nursing Facility crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
Examples	<p><u>Example 1:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 1200.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount-claim pays zero)</p> <p><u>Example 2:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 100.00</p>		

	<p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 300.00</p> <p><u>Example 3:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 812.00</p> <p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 379.03</p> <p><u>Cost Based Providers:</u></p> <p>Have their own provider contract and reimbursement rules.</p>
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4.2.9 Claim Type A: Intermediate Care Facility (ICF) Crossover (Prov Type 11)

Alpha Claim Type	A (formerly Legacy X)	Provider Type	11
Provider Contract	ICFMR	Reimbursement Classification	RC ICF/MR
Methodology/Logic	<p>Pricing Method:</p> <p>ICF Crossover claims pay 100% of the header coinsurance, plus the header deductible amount as listed on the claim form (less other insurance, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.2.10 Claim Type A: Skilled Nursing Facility (SNF) Crossover – Part A (Prov Type 11)

Alpha Claim Type	A (formerly Legacy X)	Provider Type	11
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Provider Contract	ICFMR	Reimbursement Classification	RC ICF/MR
Methodology/Logic	<p>Pricing Method:</p> <p>SNF Part A* Crossover claims pay 100% of the header coinsurance, plus the header deductible amount as listed on the claim form (less other insurance and patient liability**, if any).</p> <p style="text-align: center;">*Part A – Type of Bill 211, 212, 213, 214</p> <p>**The Patient Liability amount listed on the Member Eligibility File is a monthly amount. If the claim is billed for less than a one (1) month period, the liability amount must be prorated. To determine the pro-rated amount, multiply the liability amount by the number of days in the month for which the claim is being billed. Then divide this amount (liability amount x number of days in month) by the number of covered days.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.2.11 Claim Type A: Skilled Nursing Facility (SNF) Crossover – Part B (Prov Type 11)

Alpha Claim Type	A (formerly Legacy X)	Provider Type	11
Provider Contract	ICFMR	Reimbursement Classification	RC ICF/MR
Methodology/Logic	<p>Pricing Method:</p> <p>SNF Part B Crossover claims pay 100% of the header coinsurance, plus the header deductible amount as listed on the claim form (less other insurance, if any).</p> <p style="text-align: center;">*Part B – Type of Bill 221, 222, 223, 224</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.3 Claim Type B

4.3.1 Claim Type B: School Based Health Services Crossover (Prov Type 21)

Alpha Claim Type	B (formerly Legacy O)	Provider Type	21
Provider Contract	SBHS	Reimbursement Classification	RC Schl Base Service
Methodology/Logic	<p>School Based Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for School Based crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.3.2 Claim Type B: Vision Crossover (Prov Type 52/77)

Alpha Claim Type	B (formerly Legacy O)	Provider Type	52/77
Provider Contract	OPTI	Reimbursement Classification	RC Optician
Methodology/Logic	<p>Vision Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for Vision crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the</p>		

	<p>Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount due = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>

4.3.3 Claim Type B: Non-Emergency Transportation Crossover (Prov Type 56)

Alpha Claim Type	B (formerly Legacy B)	Provider Type	56
Provider Contract	NET NETRP	Reimbursement Classification	RC Non-Emerg Trans
Methodology/Logic	<p>Non-Emergency Transportation Crossover claims will price using the pricing method:</p> <p>LT1918 Crossover pricing is used for Non-Emergency Transportation crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the</p>		

	<p>Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount</p>
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4.3.4 Claim Type B: Pharmacy Crossover (Prov Type 54)

Alpha Claim Type	B (formerly Legacy F)	Provider Type	54
Provider Contract	PHARM	Reimbursement Classification	Standard
Methodology/Logic	<p>Pharmacy Crossover claims with header from dates of service 04/01/03 or after are priced using the MCAID-1 rate on the Procedure Display Screen 2 or the Procedure Rate File, then comparing the allowed amount to the Medicare paid amount. Please note since Medicare does not distinguish between DME procedure codes and pharmacy procedure codes, DMS crossover claims may include pharmacy procedure codes and Pharmacy crossover claims may include DMS procedure codes. Pharmacy crossover claims will price like the DME crossovers.</p> <p>NOTE: If no rate is found, the detail coinsurance and deductible is paid. No comparison to the Medicare payment is made.</p> <p>Pharmacy reimbursement is determined as follows:</p> <p>Procedure Codes Without the RR procedure Modifier</p> <p>Pharmacy procedures without the “RR” procedure modifier are priced using theMCAID-1 amount listed on the PDD File Procedure Display Screen 2. The MCAID-1 amount is multiplied by the units of service and the product (MCAID-1 x units) is compared to the billed amount. Medicaid allowed amount is the lesser of the two.</p> <p>If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any is subtracted to determine the Medicaid reimbursement.</p>		

	<p>Procedures with the RR Modifier</p> <p>Pharmacy procedure with the RR procedure modifier are priced using the Procedure Rate (PR) Pricing File. The applicable Procedure Rate amount is multiplied by the units of service and the product (PR x units) is compared to the billed amount. Medicaid allowed amount is the lesser of the two.</p> <p>If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any is subtracted to determine the Medicaid reimbursement.</p>
<p>Exceptions</p>	<p>There are no exceptions.</p>
<p>Examples</p>	<p>Example 1:</p> <p>Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount – claim pays zero)</p> <p>Example 2:</p> <p>Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 – claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3”</p> <p>Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance and Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 – claims pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>

4.3.5 Claim Type B: Transportation Crossover (Prov Type 55)

Alpha Claim Type	B (formerly Legacy B)	Provider Type	55																																				
Provider Contract	TRNSP	Reimbursement Classification	Standard																																				
Methodology/Logic	<p>Transportation Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for Transportation crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>The following Medicare Procedure codes are cross-walked to Medicaid procedure codes to determine Medicaid reimbursement (these are currently hard-coded in the claims engine):</p> <table border="1"> <thead> <tr> <th>Medicare Code</th> <th>Medicaid Code</th> <th>Medicaid Code</th> </tr> </thead> <tbody> <tr> <td></td> <td><u>DOS 6/1/2003</u></td> <td><u>DOS 10/16/2003</u></td> </tr> <tr> <td>A0225</td> <td>A0427</td> <td>A0427</td> </tr> <tr> <td>A0384</td> <td>A0382</td> <td>A0382</td> </tr> <tr> <td>A0392</td> <td>A0398</td> <td>A0398</td> </tr> <tr> <td>A0394</td> <td>A0398</td> <td>A0398</td> </tr> <tr> <td>A0396</td> <td>A0398</td> <td>A0398</td> </tr> <tr> <td>A0425</td> <td>A0390</td> <td>A0425 UA</td> </tr> <tr> <td>A0426</td> <td>A0427</td> <td>A0427</td> </tr> <tr> <td>A0428</td> <td>A0429</td> <td>A0429</td> </tr> <tr> <td>A0432</td> <td>A0429 MA</td> <td>A0429 UC</td> </tr> <tr> <td>A0433</td> <td>A0427</td> <td>A0427</td> </tr> </tbody> </table>			Medicare Code	Medicaid Code	Medicaid Code		<u>DOS 6/1/2003</u>	<u>DOS 10/16/2003</u>	A0225	A0427	A0427	A0384	A0382	A0382	A0392	A0398	A0398	A0394	A0398	A0398	A0396	A0398	A0398	A0425	A0390	A0425 UA	A0426	A0427	A0427	A0428	A0429	A0429	A0432	A0429 MA	A0429 UC	A0433	A0427	A0427
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	<table border="1"> <tr> <td>A0434</td> <td>A0427</td> <td>A0427</td> </tr> <tr> <td>Q3019</td> <td>A0427</td> <td>A0427</td> </tr> <tr> <td>Q3020</td> <td>A0427</td> <td>A0427</td> </tr> </table>	A0434	A0427	A0427	Q3019	A0427	A0427	Q3020	A0427	A0427
A0434	A0427	A0427								
Q3019	A0427	A0427								
Q3020	A0427	A0427								
<p>Exceptions</p>	<p>Procedure codes A0420, A0424 (components of the Base Rate), and A0435, A0436 (air mileage codes are incorporated in all inclusive reimbursement for air transport) pay zero.</p> <p>Procedure code A0999 and procedure codes not on file pay the detail coinsurance and deductible. No comparison to the Medicare payment is made.</p> <p>Procedure code A0425 will be priced using the rate for A0425 UA.</p>									
<p>Examples</p>	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>									

4.3.6 Claim Type B: Chiropractor Crossover (Prov Type 85)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	85
Provider Contract	CHIRO	Reimbursement Classification	RC Professional Svcs
Methodology/Logic	<p>Chiropractor Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for Chiropractor crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions		
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - Claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p>		

	<p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>
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4.3.7 Claim Type B: Clinical Social Worker Crossover (Prov Type 82)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	82
Provider Contract	QMBPT	Reimbursement Classification	Standard
Methodology/Logic	<p>Clinical Social Worker Crossover claims will price using the pricing method:</p> <p>PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Clinical Social Worker Crossover claims pay 100% of the detail deductible and coinsurance amounts (less other insurance, if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows:</p> <ol style="list-style-type: none"> 1. Claims with only 1 detail – The detail deductible amount is equal to the header deductible amount. 2. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 3. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The deductible amount is 		

	<p>applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, the deductible amount would be applied as follows:</p> <ol style="list-style-type: none"> The 1st detail would have deductible amount of \$50.00 (and no coinsurance). The 2nd detail would have deductible amount of \$25.00 [$\\75.00 (header deductible) – $\\$50.00$ (Medicare allowed/1st detail)]. This detail would also have coinsurance amount of $\\$50.00 [(\\$50.00 - \\$25.00) \times .2]$.
Exceptions	There are no exceptions.

4.3.8 Claim Type B: DME Supplier Crossover (Prov Type 90)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	90
Provider Contract	DME	Reimbursement Classification	Standard
Methodology/Logic	<p>DME Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for DME crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
Examples	<p>Example1:</p> <p>Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p>		

	<p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount – claim pays zero)</p> <p>Example 2:</p> <p>Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 – claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance and Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 – claims pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>
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4.3.9 Claim Type B: Occupational Therapist Crossover (Prov Type 88)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	88
Provider Contract	QMBPT	Reimbursement Classification	Standard
Methodology/Logic	<p>Occupational Therapist Crossover claims will price using the pricing method:</p> <p>PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p>		

	<p>Occupational Therapist Crossover claims pay 100% of the detail deductible and coinsurance amounts (less other insurance, if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows:</p> <ol style="list-style-type: none"> 1. Claims with only 1 detail – The detail deductible amount is equal to the header deductible amount. 2. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 3. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The deductible amount is applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, the deductible amount would be applied as follows: <ol style="list-style-type: none"> a. The 1st detail would have deductible amount of \$50.00 (and no c b. The 2nd detail would have deductible amount of \$25.00 [$\\75.00 (header deductible) – $\\$50.00$ (Medicare allowed/1st detail)]. This detail would also have coinsurance amount of $\\$50.00$ [$(\\$50.00 - \\$25.00) \times .2$].
Exceptions	There are no exceptions.

4.3.10 Claim Type B: Physical Therapist Crossover (Prov Type 87)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	87
Provider Contract	QMBPT	Reimbursement Classification	Standard
Methodology/Logic	<p>Physical Therapist Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p>		

	<p>Physical Therapist Crossover claims pay 100% of the detail deductible and coinsurance amounts (less other insurance, if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows:</p> <ol style="list-style-type: none"> 4. Claims with only 1 detail – The detail deductible amount is equal to the header deductible amount. 5. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 6. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The deductible amount is applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, the deductible amount would be applied as follows: <ol style="list-style-type: none"> c. The 1st detail would have deductible amount of \$50.00 (and no c <p>The 2nd detail would have deductible amount of \$25.00 [\$75.00 (header deductible) – \$50.00 (Medicare allowed/1st detail)]. This detail would also have coinsurance amount of \$50.00 [(\$50.00 – \$25.00) x .2].</p>
Exceptions	There are no exceptions.

4.3.11 Claim Type B: Psychologist Crossover (Prov Type 89)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	89
Provider Contract	QMBPT	Reimbursement Classification	Standard
Methodology/Logic	<p>Psychologist Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p>		

	<p>Psychologist Crossover claims pay 100% of the detail deductible and coinsurance amounts (less other insurance, if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows:</p> <ol style="list-style-type: none"> 4. Claims with only 1 detail – The detail deductible amount is equal to the header deductible amount. 5. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 6. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The deductible amount is applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, the deductible amount would be applied as follows: <ol style="list-style-type: none"> a. The 1st detail would have deductible amount of \$50.00 (and no coinsurance). b. The 2nd detail would have deductible amount of \$25.00 [\$75.00 (header deductible) – \$50.00 (Medicare allowed/1st detail)]. This detail would also have coinsurance amount of \$50.00 [(\$50.00 – \$25.00) x .2].
Exceptions	There are no exceptions.

4.3.12 Claim Type B: X-Ray Supplier Crossover (Prov Type 86)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	86
Provider Contract	XRAY	Reimbursement Classification	RC Oth lab and X-ray
Methodology/Logic	<p>X-Ray Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p>		

	<p>Additional Reimbursement Info:</p> <p>X-Ray Supplier Crossover claims pay 100% of the detail deductible and coinsurance amounts (less other insurance, if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows:</p> <ol style="list-style-type: none"> 7. Claims with only 1 detail – The detail deductible amount is equal to the header deductible amount. 8. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 9. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The deductible amount is applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, the deductible amount would be applied as follows: <ol style="list-style-type: none"> a. The 1st detail would have deductible amount of \$50.00 (and no coinsurance). b. The 2nd detail would have deductible amount of \$25.00 [$\\75.00 (header deductible) – $\\$50.00$ (Medicare allowed/1st detail)]. This detail would also have coinsurance amount of $\\$50.00$ [$(\\$50.00 - \\$25.00) \times .2$].
Exceptions	There are no exceptions.

4.3.13 Claim Type B: Physician Assistant Crossover (Prov Type 95)

Alpha Claim Type	B (formerly Legacy C)	Provider Type	95
Provider Contract	QMBPT	Reimbursement Classification	Standard
Methodology/Logic	<p>Physician Assistant Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for DME crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid</p>		

	<p>allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>

4.3.14 Claim Type B: Ambulatory Surgical Center (ASC) Crossover (Prov Type 36)

Alpha Claim Type	B (formerly Legacy	Provider Type	36
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Provider Contract	ASC	Reimbursement Classification	Standard
Methodology/Logic	<p>ASC Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Ambulatory Surgical Center (ASC) Crossover claims pay 100% of the detail deductible and coinsurance amounts (less other insurance if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows</p> <ol style="list-style-type: none"> 10. Claims with only 1 detail – The detail deductible amount is equal to the header deductible amount. 11. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 12. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The header deductible amount is applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has a header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, then deductible amount would be applied as follows: <ol style="list-style-type: none"> a. The 1st detail would have a deductible amount of \$50.00 (and no coinsurance). b. The 2nd detail would have a deductible amount of \$25.00 [\$75.00 (header deductible) – \$50.00 (Medicare allowed/1st detail)]. This detail would also have a coinsurance amount of \$50.00 [(\$50.00 – \$25.00) x .2]. 		
Exceptions	There are no exceptions.		

4.3.15 Claim Type B: Audiology Crossover (Prov Type 50/70)

Alpha Claim Type	B (formerly Legacy)	Provider Type	50/70
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	O)		
Provider Contract	HEAR (PT 50) AUDIO (PT 70)	Reimbursement Classification	RC Audiology
Methodology/Logic	<p>Audiology Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for Audiology crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p>		

	<p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>
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4.3.16 Claim Type B: Certified Nurse Practitioner (CNP) Crossover (Prov Type 78)

Alpha Claim Type	B (formerly Legacy O)	Provider Type	78
Provider Contract	NPRCT	Reimbursement Classification	RC Professional Svcs
Methodology/Logic	<p>Certified Nurse Practitioner Crossover claims will price using the pricing method:</p> <p>LT1918 Crossover pricing is used for Certified Nurse Practitioner crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p>		

	<p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00-claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>
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4.3.17 Claim Type B: Community Mental Health Crossover (Prov Type 30)

Alpha Claim Type	B (formerly Legacy O)	Provider Type	30
Provider Contract	COMMH	Reimbursement Classification	RC Comm Mental Healt
Methodology/Logic	<p>Community Mental Health Crossover claims will price using the pricing method:</p> <p>LT1918 Crossover pricing is used for Community Mental Health crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be</p>		

	<p>the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00, claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>

4.3.18 Claim Type B: Dental Crossover (Prov Type 60/61)

Alpha Claim Type	B (formerly Legacy	Provider Type	60/61
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	O)		
Provider Contract	DENTL	Reimbursement Classification	Standard
Methodology/Logic	<p>Dental Crossover claims will price using the pricing method:</p> <p>LT1918 Crossover pricing is used for Dental crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p>		

	<p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p>
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4.3.19 Claim Type B: Independent Lab Crossover (Prov Type 37)

Alpha Claim Type	B (formerly Legacy O)	Provider Type	37
Provider Contract	LAB	Reimbursement Classification	Standard
Methodology/Logic	<p>Independent Lab Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for Independent Lab crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p>		

	<p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount due = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>
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4.3.20 Claim Type B: Nurse Anesthetist Crossover (Prov Type 74)

Alpha Claim Type	B (formerly Legacy O)	Provider Type	74
Provider Contract	CRNA	Reimbursement Classification	Standard
Methodology/Logic	<p>Nurse Anesthetist Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for Nurse Anesthetist crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p>		

	<p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount- claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount due = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00, claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>

4.3.21 Claim Type B: Physician Crossover (Prov Type 64/65) HCFA 1500

Alpha Claim Type	B (formerly Legacy O)	Provider Type	64/65
Provider Contract	PHYS	Reimbursement Classification	RC Professional Svcs
Methodology/Logic	<p>Physician Crossover claims will price using the following Crossover Pricing methods:</p> <ul style="list-style-type: none"> • LT1918 - Allow lesser of ['Reprice' amount minus Medicare Paid] or [coinsurance + deductible] • DTPD18 - Deduct Medicare Paid Amount from 'Reprice' amount (no comparison to coinsurance + deductible) <p>Pricing Method:</p> <p>To determine crossover pricing calculate the <i>regular, non-crossover</i> Medicaid allowed amount (also called the 'reprice' amount) for the procedure (see section M: Physician, of this manual), then apply the applicable Crossover Pricing method below.</p> <p><u>LT1918</u>, used for all procedure codes with the exception of J2794 for dates of service 01/01/2010 and after, compares the regular, non-crossover Medicaid allowed/reprice amount to the detail Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed/reprice amount, the claim will pay zero. If the regular Medicaid allowed/reprice amount is greater than the Medicare paid amount, reimbursement will be the difference (of regular Medicaid allowed/reprice amount minus Medicare paid amount) up to the total of detail coinsurance plus detail deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p><u>DTPD18</u> is used for procedure code J2794 for dates of service 01/01/2010 and after. To determine Medicaid reimbursement subtract the detail Medicare paid amount from the regular Medicaid allowed/reprice amount, then subtract other insurance, if any.</p> <p>Default Pricing Logic: See section M: Physician</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>For procedure code 77424 the number of units is not multiplied by the procedure rate when the claim is repriced for crossovers.</p>		
Exceptions	There are no exceptions.		
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p>		

	<p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount due = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p> <p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>
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4.3.22 Claim Type B: Preventive Services Crossover (Prov Type 20)

Alpha Claim Type	B (formerly Legacy O)	Provider Type	20
Provider Contract	PREVH	Reimbursement Classification	RC Prev Health
Methodology/Logic	<p>Preventive Services Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Preventive Services Crossover claim pay 100% of the detail deductible and coinsurance amounts (less other insurance, if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows:</p> <ol style="list-style-type: none"> 13. Claims with only 1 detail – The deductible amount is equal to the header deductible amount. 14. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 15. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The header deductible amount is applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has a header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, then deductible amount would be applied as follows: <ol style="list-style-type: none"> a. The 1st detail would have a deductible amount of \$50.00 (and no coinsurance). b. The 2nd detail would have a deductible amount of \$25.00 [\$75.00 (header deductible) – \$50.00 (Medicare allowed/1st detail)]. This detail would also have a coinsurance amount of \$50.00 [(\$50.00 – \$25.00) x .2]. 		
Exceptions	There are no exceptions.		

4.3.23 Claim Type B: Primary Care Crossover (Prov Type 31)

Alpha Claim Type	B (formerly Legacy W)	Provider Type	31
Provider Contract	PCARE	Reimbursement Classification	RC PriCare/RuralHlth
Methodology/Logic	<p>Primary Care Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.3.24 Claim Type B: Rural Health Crossover (Prov Type 35)

Alpha Claim Type	B (formerly Legacy W)	Provider Type	35
Provider Contract	RHC	Reimbursement Classification	RC PriCare/RuralHlth
Methodology/Logic	<p>Rural Health Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail)</p> <p>Pricing Method:</p> <p>The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.3.25 Claim Type B: Podiatry Crossover (Prov Type 80)

Alpha Claim Type	B (formerly Legacy Z)	Provider Type	80
Provider Contract	PODI	Reimbursement	RC Professional Svcs

	Classification
Methodology/Logic	<p>Podiatry Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for Podiatry crossover claims.</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.
Examples	<p>Example 1:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 210.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount - claim pays zero)</p> <p>Example 2:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 160.00</p> <p>Difference = 40.00</p> <p>Coinsurance plus Deductible Amount = 50.00</p> <p>Medicaid Reimbursement = 40.00. Medicaid allowed minus Medicare paid amount equals 40.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount.</p> <p>Example 3:</p> <p>Regular/Straight Medicaid Allowed = 200.00</p> <p>Medicare Paid = 80.00</p>

	<p>Difference = 120.00</p> <p>Coinsurance plus Deductible Amount = 100.00</p> <p>Medicaid Reimbursement = 100.00. Medicaid allowed minus Medicare paid amount equals 120.00 - claim pays the difference between the Medicaid Allowed amount and the Medicare Paid amount but not to exceed the coinsurance or deductible amount.</p>
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4.4 Claim Type C

4.4.1 Claim Type C: Comprehensive Outpatient Rehab Facility (CORF) Crossover (Prov Type 91)

Alpha Claim Type	C (formerly Legacy C)	Provider Type	91
Provider Contract	CORFX	Reimbursement Classification	Standard
Methodology/Logic	<p>CORF Crossover claims will price using the pricing method: PCH100 (Pay Xover 100% Header) and a rate type of NA (Not Applicable)</p> <p>Pricing Method:</p> <p>The PCH100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the header amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.4.2 Claim Type C: Home Health Crossover (Prov Type 34)

Alpha Claim Type	C (formerly Legacy O)	Provider Type	34
Provider Contract	HHLTH	Reimbursement Classification	RC Home Health
Methodology/Logic	<p>Home Health Crossover claims will price using the pricing method: PCH100 (Pay Xover 100% Header) and a rate type of NA (Not Applicable)</p> <p>Pricing Method:</p> <p>The PCH100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the header amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.4.3 Claim Type C: Outpatient Hospital Crossover (Prov Type 01) – UB92 Claims

Alpha Claim Type	C (formerly Legacy W)	Provider Type	01
Provider Contract	OPHOS (Outptnt Hosp) NACOP (Critical Access) Prov Type – 01 Prov Spec - 014 UNVOP (University Hosp)	Reimbursement Classification	RC Outpatient Hosp
Methodology/Logic	<p>Outpatient Hospital Crossover claims will price using the pricing method: LT1918 Crossover pricing is used for outpatient hospital crossover claims. PCH100 (Pay Xover 100% Header)</p> <p>Pricing Method:</p> <p>The LT1918 crossover pricing will pay the lesser of the Medicaid or Medicare.</p> <p>Calculate the <i>regular</i> Medicaid allowed amount, then comparing the regular Medicaid allowed amount to the Medicare paid amount. If the Medicare paid amount is greater than or equal to the regular Medicaid allowed amount, the claim will pay zero. If the regular Medicaid allowed amount is greater than the Medicare paid amount, reimbursement will be the difference up to the total coinsurance and deductible amount (but not exceeding). Other insurance, if any, is subtracted to determine Medicaid reimbursement. (see examples below).</p> <p>The PCH100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the header amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>If DOS is 9/1/2003 – 12/31/2299</u></p> <p>The LT1918 crossover pricing is applied.</p>		

	<p><u>If DOS is prior to of on 8/31/2003</u></p> <p>The PCH100 pricing method was used for Outpatient crossover claims.</p>
Examples	<p><u>Example 1:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 1200.00</p> <p>Medicaid Reimbursement = 0.00 (Medicare Paid amount is more than Medicaid allowed amount-claim pays zero)</p> <p><u>Example 2:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 100.00</p> <p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 300.00</p> <p><u>Example 3:</u></p> <p>Regular Medicaid Allowed = 1179.03</p> <p>Medicare Paid = 800.00</p> <p>Coinsurance = 200.00</p> <p>Deductible = 812.00</p> <p>Difference between Medicaid Allowed and Medicare Paid amount = 379.03</p> <p>Medicaid Reimbursement = 379.03</p>
Exceptions	<p>There are no exceptions.</p>

4.4.4 Claim Type C: Outpatient Hospital (Prov Type 01) Crossovers-HCFA Claims

Alpha Claim Type	C (formerly Legacy W)	Provider Type	01
Provider Contract	OPHOS (Outptnt Hosp) NACOP (Critical Access)	Reimbursement Classification	RC Outpatient Hosp

	Prov Type – 01 Prov Spec - 014 UNVOP (University Hosp)		
Methodology/Logic	Outpatient Hospital Crossover claims will price using the pricing method: PCD100 (Pay Xover 100% Detail) Pricing Method: The PCD100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the detail amount. Default Pricing Logic: None Pricing Method - Services which price from PA: None Additional Reimbursement Info: Outpatient Hospital Crossover claims submitted on the HCFA-1500 form pays 100% of the detail deductible and coinsurance amounts (less other insurance, if any). Note: Detail coinsurance is computed by subtracting the detail deductible from the detail Medicare allowed amount and multiplying the remainder by 20%. Detail deductible is computed as follows: <ol style="list-style-type: none"> 16. Claims with only 1 detail – The deductible amount is equal to the header deductible amount. 17. Claims with multiple details/header deductible less than or equal to Medicare allowed amount of 1st detail – The deductible amount for the 1st detail is equal to the header deductible amount. The deductible amount for all other details is zero. 18. Claims with multiple details/header deductible greater than Medicaid allowed amount of 1st detail – The header deductible amount is applied to each detail in descending order until the total header deductible has been applied. For example, if a claim has a header deductible amount of \$75.00 and two details, each with a Medicare allowed amount of \$50.00, then deductible amount would be applied as follows: <ol style="list-style-type: none"> c. The 1st detail would have a deductible amount of \$50.00 (and no coinsurance). d. The 2nd detail would have a deductible amount of \$25.00 [\$75.00 (header deductible) – \$50.00 (Medicare allowed/1st detail)]. This detail would also have a coinsurance amount of \$5.00 [(\$50.00 – \$25.00) x .2] 		
Exceptions	There are no exceptions.		

4.4.5 Claim Type C: Renal Dialysis Crossover (Prov Type 39)

Alpha Claim Type	C (formerly Legacy W)	Provider Type	39
Provider Contract	DLYIS	Reimbursement Classification	RC Renal Dialysis
Methodology/Logic	<p>Renal Dialysis Crossover claims will price using the pricing method: PCH100 (Pay Xover 100% Header)</p> <p>Pricing Method:</p> <p>The PCH100 pricing method pays 100% of the Medicare coinsurance and deductible at 100% of the header amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.4.6 Claim Type C: Primary Care Crossover (Prov Type 31)

Alpha Claim Type	C (formerly Legacy W)	Provider Type	31
Provider Contract	PCARE	Reimbursement Classification	RC PriCare/RuralHlth
Methodology/Logic	<p>Primary Care Crossovers submitted in UB04XO format will price using the pricing method:</p> <p>PCH100 (100% of header Coinsurance and Deductible)</p> <p>Pricing Method:</p> <p>The PCH100 pricing method pays 100% of the header Medicare coinsurance and deductible, less other insurance, if any.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.4.7 Claim Type C: Rural Health Crossover (Prov Type 35)

Alpha Claim Type	C (formerly Legacy W)	Provider Type	35
Provider Contract	RHC, RHCLC	Reimbursement Classification	RC PriCare/RuralHlth
Methodology/Logic	<p>Rural Health Crossovers submitted in UB04XO format will price using the pricing method:</p> <p>PCH100 (100% of header Coinsurance and Deductible)</p> <p>Pricing Method:</p> <p>The PCH100 pricing method pays 100% of the header Medicare coinsurance and deductible less other insurance, if any.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.5 Claim Type D

4.5.1 Claim Type D: Dental (Prov Type 60/61)

Alpha Claim Type	D (formerly Legacy L)	Provider Type	60/61																
Provider Contract	DENTL	Reimbursement Classification	RC Professional Svcs																
Methodology/Logic	<p>Dental claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing methodology will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type P4O (oral pathologist only) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).</p> <p>Note: Copay for dental claims is accumulative only and is not deducted from the claim. Units on a dental claim will be a value of 1.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be preformed. The reimbursement is 65% of the billed amount.</p> <p>Pricing Method - Services which price from PA: Comprehensive Orthodontic services (i.e. procedure code) will have a “Y” PA indicator on the provider contract for the provider (dentist). The LPABIL (Lesser of PA or Bill Amt) will be used. This compares the PA amount versus the Max Fee for the service (i.e. procedure code). The reimbursement is determined by comparing the detail billed amount to the prior authorized amount listed on the Prior Authorization file. Medicaid reimbursement is the lesser of the two (less copay amount and other insurance and spenddown, if any).</p> <p>Additional Reimbursement Info: Effective with dates of service 8/15/06 – 12/31/2299 for members age 20 and under, an additional 30% will be added to the existing rate on file for the following procedure codes:</p> <p>This is accomplished by using a Benefit Adjustment Factor (BAF) in the reimbursement rules for the services listed below and the parameters listed above (i.e. date of service, age, BAF percentage). The BAF is a configurable parameter for the reimbursement rules.</p> <table border="1" data-bbox="669 1738 1281 1896"> <tr> <td>D0210</td> <td>D2150</td> <td>D2932</td> <td>D5640</td> <td>D7250</td> </tr> <tr> <td>D0220</td> <td>D2160</td> <td>D3220</td> <td>D5750</td> <td>D7260</td> </tr> <tr> <td>D0230</td> <td>D2161</td> <td>D3310</td> <td>D5751</td> <td>D7310</td> </tr> </table>				D0210	D2150	D2932	D5640	D7250	D0220	D2160	D3220	D5750	D7260	D0230	D2161	D3310	D5751	D7310
D0210	D2150	D2932	D5640	D7250															
D0220	D2160	D3220	D5750	D7260															
D0230	D2161	D3310	D5751	D7310															

	D0270	D2330	D3320	D5820	D7320
	D0272	D2331	D3330	D5821	D7410
	D0274	D2332	D3410	D5931	D7510
	D0340	D2335	D3421	D7111	D7520
	D1110	D2391	D3425	D7140	D7530
	D1201	D2392	D4210	D7210	D7910
	D1351	D2393	D4311	D7220	D7960
	D1510	D2394	D4341	D7230	D9110
	D1515	D2930	D5610	D7240	D9241
	D2140	D2931	D5620	D7241	D9420
	<p>The Benefit Adjustment Factor (BAF) is set-up within the Reference subsystem.</p> <p>The rate type P4O will be used for specialty 276 (oral pathologist) to price the following laboratory procedure codes when billed on the ADA claim form effective with date of service 1/1/2011 per CO 16634: 83912, 86485, 88104, 88300, 88304 – 88305, 88307, 88309, 88311 – 88313, 88321, 88323, 88325, 88342, 88346, and 88365.</p>				
Exceptions	There are no exceptions.				

4.6 Claim Type H

4.6.1 Claim Type H: Hospice (Prov Type 44)

Alpha Claim Type	H (formerly Legacy H)	Provider Type	44
Provider Contract	HSPCE	Reimbursement Classification	RC Hospice
Methodology/Logic	<p>Hospice claims will price using the pricing method:</p> <p>MBRCTY (Member County Pricing)</p> <p>NFUNIT (UB92 Hospice LTC)</p> <p>REVFEE (Revenue Flat Fee)</p> <p>HSXWLK (Hospice Crosswalk Pricing)</p> <p>BILLED (Billed)</p> <p>Pricing Method(s):</p> <p>The MBRCTY pricing method will get the member's county rate using the (HO1) rate type for the date of service on the claim (detail). The member's specific rate can be found on the County Rate panel for that member (Reference subsystem). The from DOS from the detail is used to get the member's county. If no county is found, a default county of 999 is used. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>The NFUNIT pricing method will get the NF1 nursing facility rate for the detail From date of service and the provider number listed in the Facility ID field on the claim. The NF1 rate is multiplied by the units. The product of rate X units is then multiplied by a 95% Benefit Adjustment Factor (BAF). This value is not compared to the billed amount. The reimbursement is the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>The REVFEE pricing method will get the revenue flat fee using the (HO3) rate type for the date of service on the claim (detail). The revenue flat fee can be found on the Flat Fee panel (Reference subsystem). The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>The HSXWLK pricing method will get provider per unit rate for that provider. FYI - no panel exists for the rates on this table – data for this pricing method is on the T_REV_HOSPICE_XWALK table)</p>		

	<p><u>Service 655 (Revenue Code – Inpatient Respite Care)</u></p> <p>This service is limited to one unit per date of service. Pricing is determined by the number of units billed.</p> <p>In all situations, if the billed amount is less than the calculated (allowed) amount, the billed amount will be the reimbursement amount.</p> <p><u>If units is 1 to 5 units:</u></p> <p>Units 1 – 4 pay at the 655 revenue code rate. Unit 5 will pay at the 651 revenue code rate.</p> <p>If the patient status code is 41, (EXPIRED IN A MEDICAL FACILITY) and the detail TDOS equals the header TDOS, then all 5 units will pay at the 655 rate.</p> <p><u>If units is grater than 6 units:</u></p> <p>Units 1 – 5 will pay at the 655 revenue code rate. The remaining units will pay at the 651 revenue code rate.</p> <p><u>Service 656 (Revenue Code – General Inpatient Care)</u></p> <p>The service is limited to one unit per date of service. All the services will price at the 656 rate except for the last unit. The last unit will price at the 651 revenue code rate.</p> <p>If the patient status code is 41, (EXPIRED IN A MEDICAL FACILITY) and the detail TDOS equals the header TDOS, then all 5 units will pay at the 656 rate.</p> <p>If the claim has a patient status code of 30 and the type of bill ends with 2 or 3, all units are priced at the 656 rate.</p> <p>In all situations, if the billed amount is less than the calculated (allowed) amount, the billed amount will be the reimbursement amount.</p> <p>The BILLED pricing method will reimburse the detail billed amount on the claim (less patient liability and other insurance, if any).</p> <p><u>Services 155, 183, 185 (Revenue Codes)</u></p> <p>These services will use the NFUNIT pricing method with a rate type of NF1.</p> <p><u>Service 250 (Revenue Code)</u></p> <p>This service will use the BILLED pricing method with a rate type of NA.</p>
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	<p><u>Services 651, 652 (Revenue Codes)</u></p> <p>These services will use the MBRCTY pricing method with a rate type of HO1.</p> <p><u>Service 656 (Revenue Codes)</u></p> <p>These services will use the HSXWLK pricing method with a rate type of HO4.</p> <p><u>Service 655 (Revenue Codes)</u></p> <p>These services will use the HSXWLK pricing method with a rate type of HO5.</p> <p><u>Services 658, 659 (Revenue Codes)</u></p> <p>These services will use the REVFEE pricing method with a rate type of HO3. 658 - Respite Care Co-pay. This procedure is limited to one unit per day. 659 - Drug Co-pay. This procedure is not limited by days.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.6.2 Claim Type H: Home And Community Based Waiver (HCB) (Prov Type 42)

Alpha Claim Type	H (formerly Legacy U)	Provider Type	42
Provider Contract	HCBWV	Reimbursement Classification	RC HCB Waiver
Methodology/Logic	<p>Home and Community Based Waiver claims will price using the pricing methods:</p> <p>PPRUNL (Provider Priced)</p> <p>REVFEE (Max Fee)</p> <p>BILLED (Billed)</p> <p>Pricing Method(s):</p> <p>For all claims other than MFP, the PPRUNL pricing method is used for all revenue codes with the exception of 290 and 660. The PPRUNL gets the provider's specific rate using the applicable rate type (see list below) for the claim date of service. A provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units. This value (rate X units) is compared to the billed amount and reimbursement is the lesser of the two (less patient liability and other insurance, if any).</p>		

Revenue codes 290 and 660 (for all claims other than those submitted on ABI LTC Waiver members) are reimbursed 100% of the detail billed amount (less patient liability and other insurance, if any). For ABI LTC Waiver member claims revenue code 660 uses the PPRUNL pricing method discussed above. Please note these two revenue codes are subject to limitation audits.

HCB Rate Types

Members with a Michelle P Waiver assignment plan:

Revenue Code	Rate Type
420	HB0
430	HB1
440	HB2
551	HB3
552	HB4
580	HB5
581	HB6
582	HB7
589	HB8
590	HB9

Members with an ABI LTC Waiver assignment plan:

Revenue Code	Rate Type
420	HA7
430	HA0
440	HA1

		<table border="1"> <tr> <td>550</td> <td>HA2</td> </tr> <tr> <td>589</td> <td>HA3</td> </tr> <tr> <td>660</td> <td>HA6</td> </tr> <tr> <td>900</td> <td>HA4</td> </tr> <tr> <td>916</td> <td>HA5</td> </tr> </table>	550	HA2	589	HA3	660	HA6	900	HA4	916	HA5								
550	HA2																			
589	HA3																			
660	HA6																			
900	HA4																			
916	HA5																			
		<p>All other members:</p> <table border="1"> <thead> <tr> <th>Revenue Code</th> <th>Rate Type</th> </tr> </thead> <tbody> <tr> <td>410</td> <td>HC7</td> </tr> <tr> <td>551</td> <td>HC1</td> </tr> <tr> <td>552</td> <td>HC2</td> </tr> <tr> <td>580</td> <td>HC3</td> </tr> <tr> <td>581</td> <td>HC4</td> </tr> <tr> <td>582</td> <td>HC5</td> </tr> <tr> <td>590</td> <td>HC6</td> </tr> <tr> <td>852</td> <td>HC8</td> </tr> </tbody> </table>	Revenue Code	Rate Type	410	HC7	551	HC1	552	HC2	580	HC3	581	HC4	582	HC5	590	HC6	852	HC8
Revenue Code	Rate Type																			
410	HC7																			
551	HC1																			
552	HC2																			
580	HC3																			
581	HC4																			
582	HC5																			
590	HC6																			
852	HC8																			
		<p><u>Money Follows the Person (MFP) Claims</u></p> <p>For claims submitted for members with an MFP assignment plan the REVFEE pricing method is used for all applicable HCB revenue codes with the exception of 294. The REVFEE pricing method obtains the rate for the revenue code from the Revenue Code Flat Fee panel for rate type MFP for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance <u>and patient liability</u>, if any).</p> <p>Revenue code 294 allows 100% of the billed amount until the dollar limit on the prior authorization is reached (monitored by PA Edit 3006). Only the authorized dollar amount will be placed on PAs for these procedure</p>																		

	<p>codes. Units of service will not be placed on the PA and will not be considered in the pricing. Once the prior authorized dollar amount is reached, no additional payment will be made.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.6.3 Claim Type H: Home Health Care Claims (Prov Type 34)

Alpha Claim Type	H (formerly Legacy U)	Provider Type	34
Provider Contract	HHLTH	Reimbursement Classification	RC Home Health
Methodology/Logic	<p>Home Health Care claims will price using the pricing method: PPRUNL (Provider Priced)</p> <p>Pricing Method(s):</p> <p>The PPRUNL pricing method will get the provider's specific percentage rate using the (HH1), (HH2), (HH3), (HH4), (HH5), (HH6), (HH7), (HH8) rate type for the date of service on the claim (detail). The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p><u>Services 270, 279, 420, 430, 440, 550, 560, 570 (Revenue Codes)</u></p> <p>These services will use the PPRUNL pricing method with a rate type of (HH1), (HH2), (HH3), (HH4), (HH5), (HH6), (HH7), or (HH8).</p> <p>Please note, the HH2 rate type is used to support the rate used prior to and on 6/30/2000 for revenue code 279.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.7 Claim Type I

4.7.1 Claim Type I: Organ Transplant Claims Inpatient Hospital (PT-01)

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	HOSP NACIP (Non Acute Care Inpt) - Critical Access, Rehab, and Ventilator	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Organ Transplant claims will price using the pricing method:</p> <p>AUTMAN (Transplant Pricing)</p> <p>MANUAL (Manual)</p> <p>Pricing Method(s):</p> <p>The AUTMAN pricing method will pay the lesser of \$75,000 or 80% of the net billed charges. An In-state hospital claim, based on the out of state provider indicators, will use the AUTMAN pricing method. See the reimbursement rule(s) for the specific service and parameters that apply (i.e. provider contract, out-of-state provider indicators, ICD-9, type of bill, claim type).</p> <p>The MANUAL pricing method will be manual priced by the user. An out-of-state claim, based on the out of state provider indicators, will be manually priced. See the reimbursement rule(s) for the specific service and parameters that apply (i.e. provider contract, out-of-state provider indicators, ICD-9, type of bill, claim type).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		
	<p>Services</p> <p>335, 3350, 3351, 3352, 336, 375, 4100, 4101, 4102, 4103, 4104, 4105, 4106, 4107, 4108, 4109, 4697, 505, 5051, 5059, 6353, 6592</p>		

4.7.2 Claim Type I: Out Of State Transplant/Related Claims (PT 01)

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	Must meet	Reimbursement Classification	Must meet
Methodology/Logic	<p>Out of State Transplant/Related claims will price using the pricing method: PAPCTB</p> <p>Pricing Method(s):</p> <p>This pricing method will look to see if the provider and member have a contracted rate on the provider contract rate panel for the date of service. If so, to determine the Medicaid allowed amount, the detail non-covered amount is subtracted from the detail billed amount and the remainder is multiplied by the applicable (based on date of service) Contract rate. Medicaid reimbursement is determined by subtracting the other insurance amount, if any.</p> <p>This pricing method applies to both inpatient and outpatient claims.</p> <p>Default Pricing Logic: With no contract rate, the AUTMAN or MANUAL method of reimbursement is used.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.7.3 Claim Type I: Inpatient Hospital (PT 01) – DRG Pricing/TDOS Greater Than 10/14/2007

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	HOSP	Reimbursement Classification	RC Inpatient DRG
Methodology/Logic	<p>Inpatient Hospital DRG claims with To Dates of Service of 10/15/2007 and after price using the pricing methods:</p> <p>DRG (DRG)</p> <p>DRGACN (DRG Transfer Out Pricing)</p> <p>DRGPAN (DRG Transfer to Post Acute/No Special Rule Pricing)</p> <p>DRGPAS (DRG Transfer to Post Acute/With Special Rule Pricing)</p> <p>DRGPSY (Psychiatric DRG Pricing)</p> <p>ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The DRG pricing methods listed above, other than ZEROPD, use the Diagnosis Related Groups (DRG) rates and indicators. The DRG rates and indicators can be found on the DRG Rates panel. The appropriate DRG rates and indicators segment is determined based on the claim header To Date of Service.</p> <p>These pricing methods also use the provider DRG rates found on the Provider DRG Rate panel. A Rate Type of DRP is used for psychiatric DRG rates. A rate type of DRG is used for all other provider DRG rates. The appropriate provider DRG rate segment is determined based on the claim header To Date of Service.</p> <p>The ZEROPD pricing method pays zero dollars. The status of the detail will be paid.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Inpatient hospital claims (including Part A crossovers), with the exception of the exclusions listed below, are reimbursed using the DRG (Diagnosis Related Groups) logic outlined in the flowcharts on the following pages. The Medicaid allowed amount is <u>not</u> compared to the billed amount. The reimbursement is the calculated allowed amount (less other insurance, spenddown, and copay, if any).</p> <p>If the provider is a Level II Neonatal Facility DRGs 385 through 390 are systematically converted to DRGs 675 through 680. If the provider is a Level III Neonatal Facility DRGs 385 through 390 are systematically converted to</p>		

DRGs 685 through 690. The converted DRGs are used for pricing in these cases and are displayed in the "Enhanced DRG" field on the DRG portion of the claims panel.

Level II Facilities:	
01012152	01010958
01014844	01022193
01011550	01010552
01012566	01022219
01021823	01021757
01022201	01011154
01013671	01009844
01012251	01022441
01012053	01022557
01011956	01000090
01010859	7100116650
7100116580	01021799 (eff 09/01/2008)
Level III Facilities:	
01690049	01022433
01012871	01013978
01012764	

Hospital Required Condition (HAC) Processing

For DRG claims with a From Date of Service greater than 06/30/2010 (including crossovers), diagnosis codes listed in the HAC Diagnosis list below are suppressed from the DRG grouper and therefore not considered in the DRG assignment process if they are submitted with a Present on Admission Indicator (POA) other than "Y" (Diagnosis was present at time of admission) or "W" (Clinically Undetermined).

Claims with a diagnosis code that has been suppressed will be assigned EOB 9304 - DUE TO CONDITIONS NOT PRESENT ON ADMISSION SOME DIAGNOSIS CODES WERE NOT CONSIDERED IN THE DRG ASSIGNMENT PROCESS. THIS MAY HAVE AFFECTED YOUR PAYMENT.

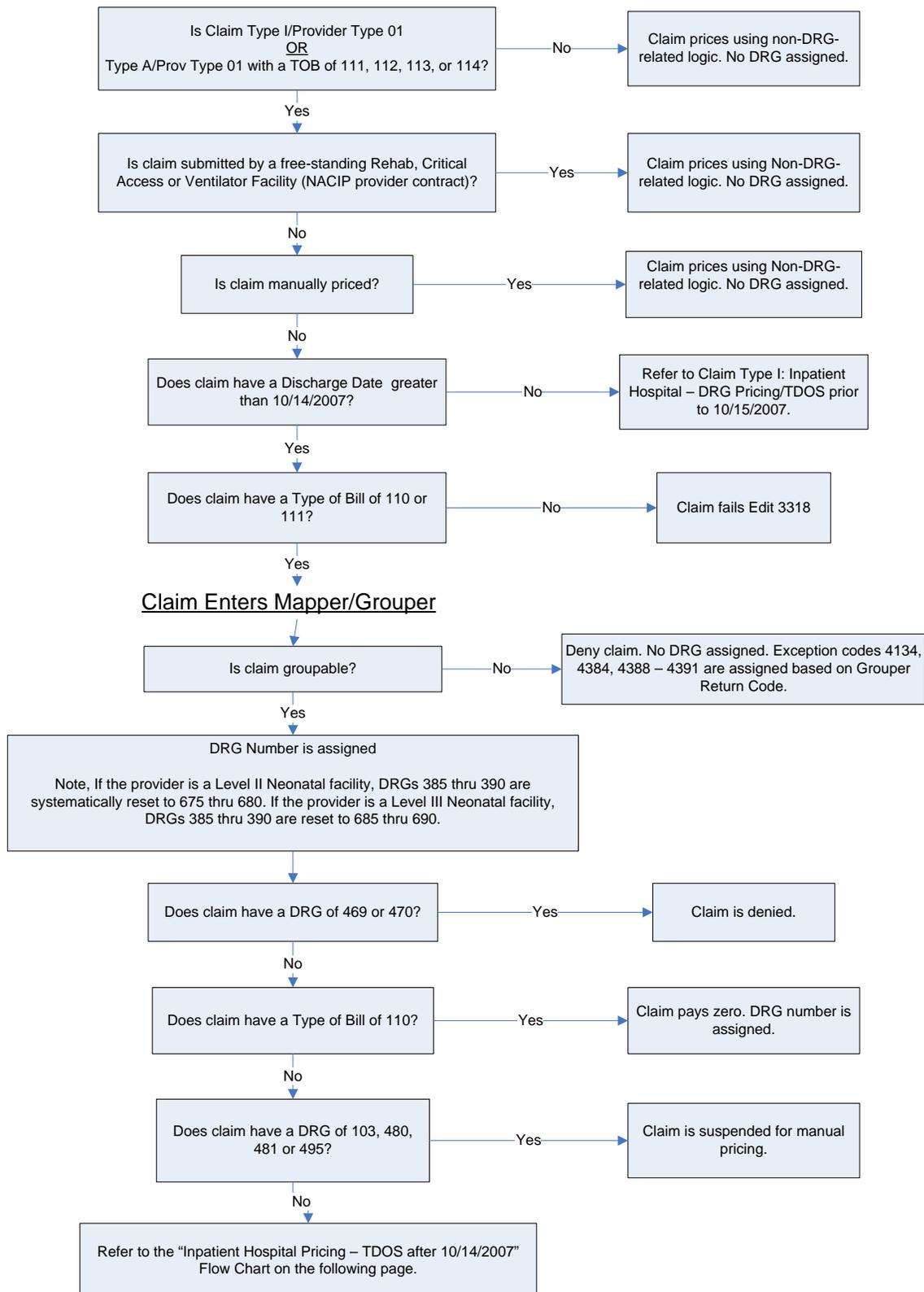
HAC diagnosis are:

HAC Description	Applicable ICD-9 Codes
Foreign Object Retained After Surgery	998.4 and/or 998.7
Air Embolism	999.1
Blood Incompatibility	999.6
Pressure Ulcers Stages III and IV	707.23 and/or 707.24
Falls and Trauma Fractures Dislocations Intracranial Injuries Crushing Injuries Burns Electric Shock	Diagnosis Codes within these ranges from the CC/MCC list (see ICD-9 Manual): 800 thru 829.99 830 thru 839.99 850 thru 854.99 925 thru 929.99 940 thru 949.99 991 thru 994.99
Catheter-Associated Urinary Tract Infection (UTI)	996.64
Vascular Catheter-Associated Infection	999.31
Manifestations of Poor Glycemic Control	250.10 thru 250.13 250.20 thru 250.23 249.10 thru 249.11 249.20 thru 249.21 251.0
Surgical Site Infection, Mediastinitis After Coronary Artery Bypass Graft (CABG)	519.2 with one of the following procedure codes: 36.10 thru 36.19

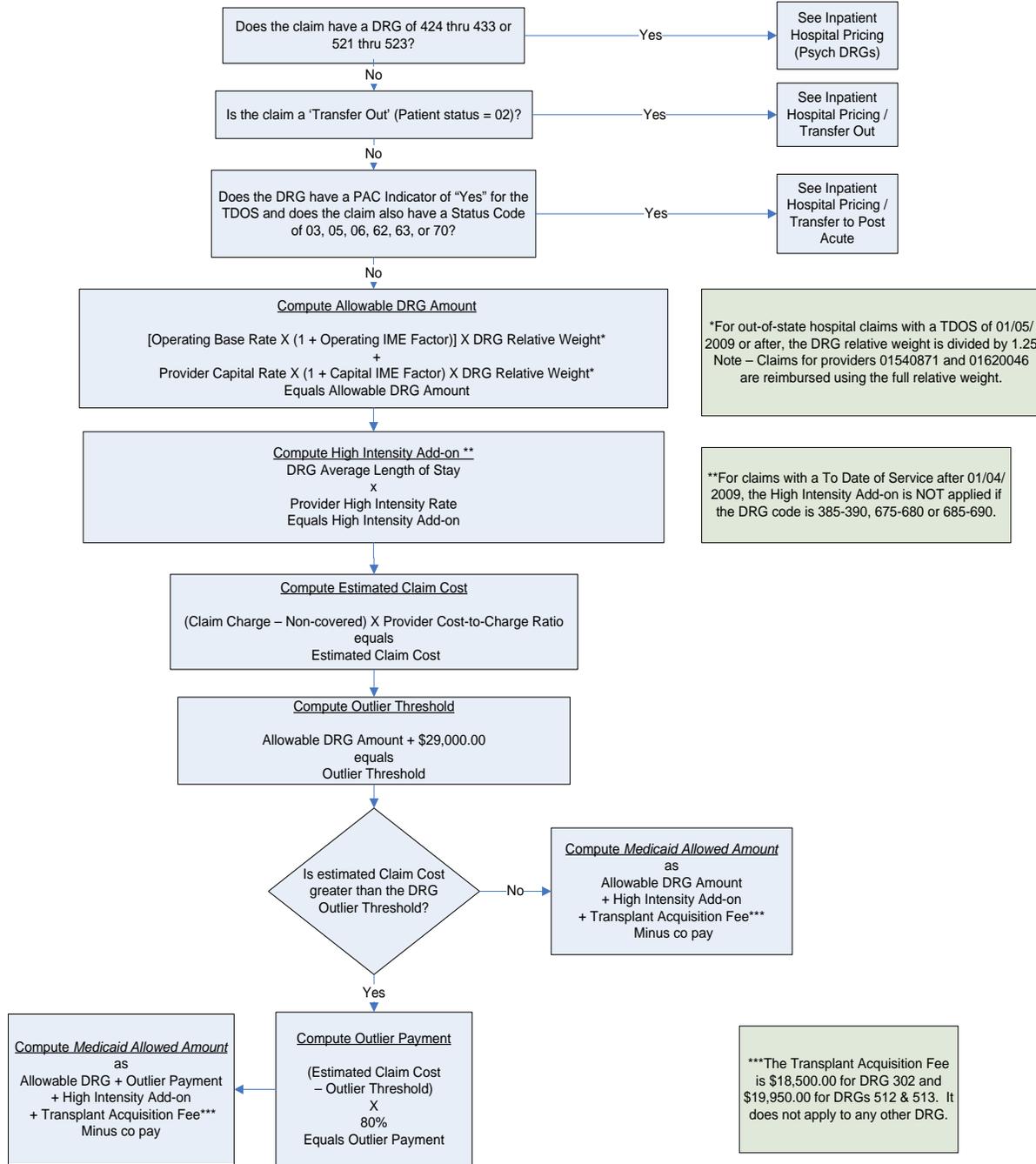
	Surgical Site Infection Following Certain Orthopedic Procedures	<p>999.67 and/or 998.59</p> <p>with one of the following procedure codes:</p> <p>81.01 thru 81.08</p> <p>81.23 thru 81.24</p> <p>81.31 thru 81.38</p> <p>81.83</p> <p>81.85</p>
	Surgical Site Infection Following Bariatric Surgery for Obesity	<p>998.59 with a <u>principle</u> diagnosis of 278.01 <u>and</u> with one of the following procedure codes:</p> <p>44.38</p> <p>44.39</p> <p>44.95</p> <p>Note – in this case the POA indicator for 278.01 is irrelevant. If 998.59 has a POA indicator of N or U and the other conditions are met, 998.59 will be suppressed from the grouper. 278.01 will not be suppressed.</p>
	Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) Following Certain Orthopedic Procedures	<p>453.40 thru 453.42, 415.11, and/or 415.19</p> <p>with one of the following procedure codes:</p> <p>81.54</p> <p>00.85 thru 00.87</p> <p>81.51 thru 81.52</p>
<p>DRG Pricing Exclusions</p> <p>Claims with a type of bill of 110 are assigned a DRG number but are not priced using the DRG logic. These claims pay zero. The ZEROPD pricing method is used and reimbursement rules exist to support this situation.</p> <p>Manually priced claims are excluded from DRG pricing. The only inpatient</p>		

	<p>hospital claims currently being manually priced are certain types of transplants.</p> <p>Claims submitted by critical access, freestanding rehab, and ventilator facilities are excluded from DRG pricing. These providers have their own provider contract (NACIP).</p>
Exceptions	<p>There are no exceptions.</p>

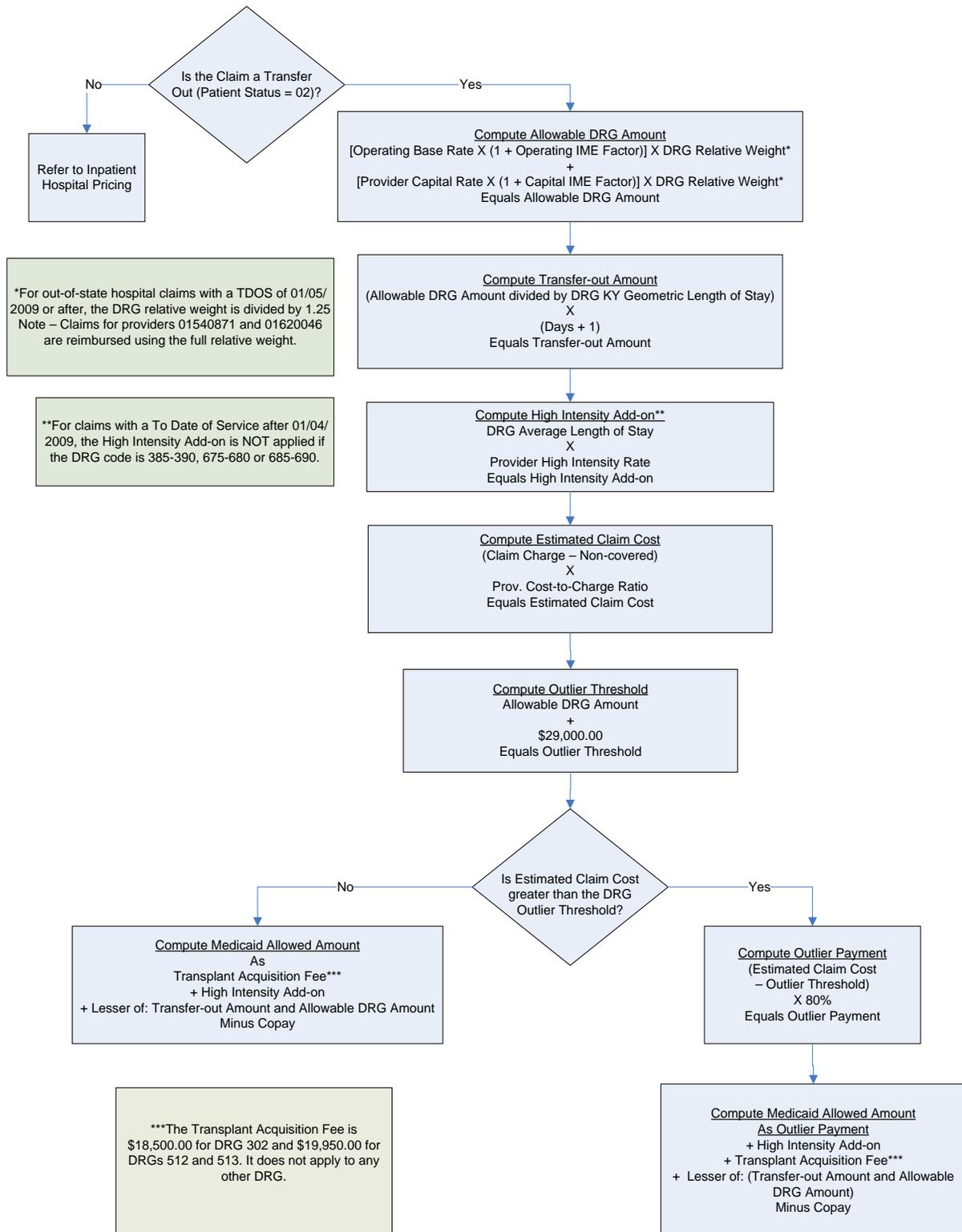
DRG FLOW CHART



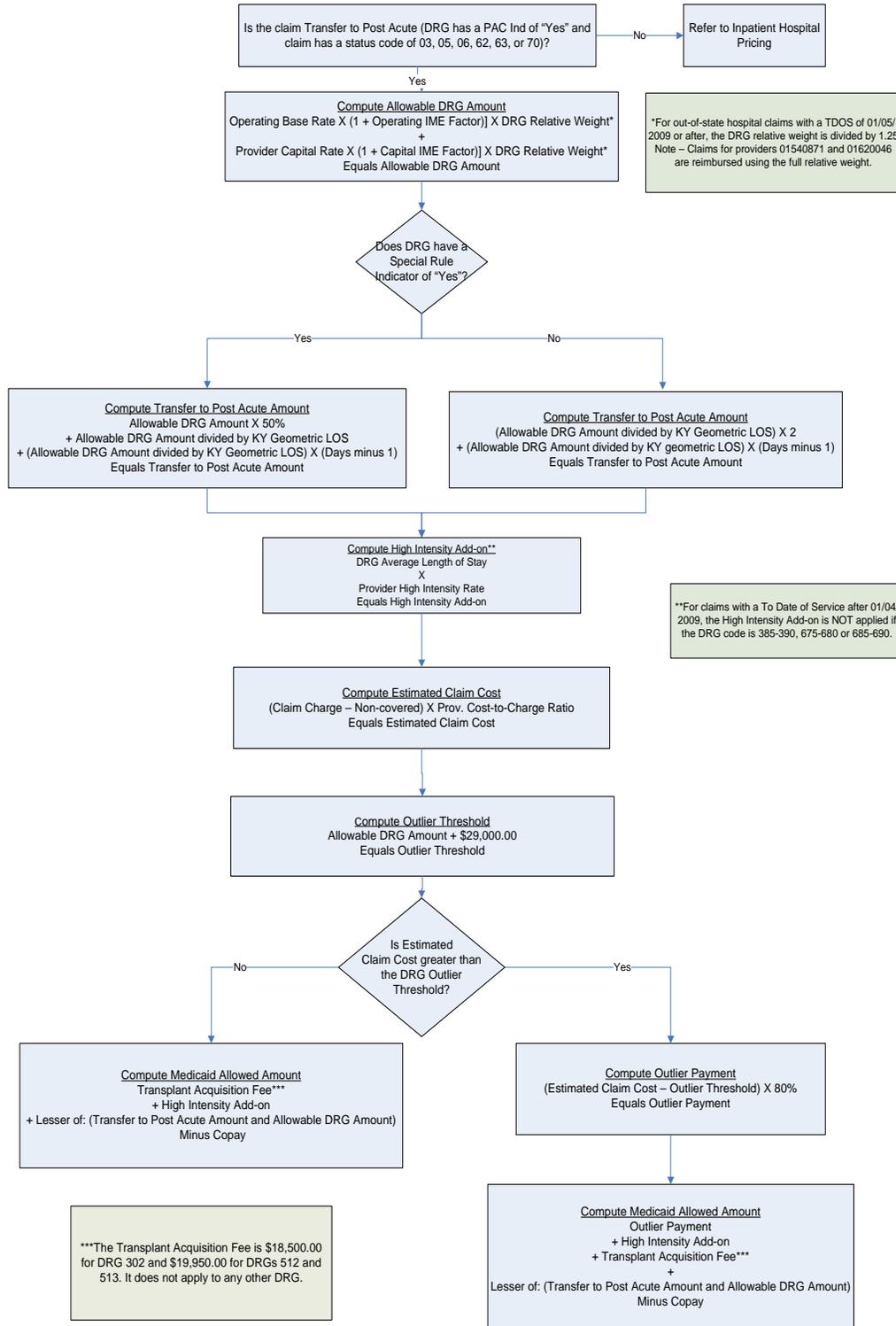
Inpatient Hospital Pricing (TDOS after 10/14/2007)



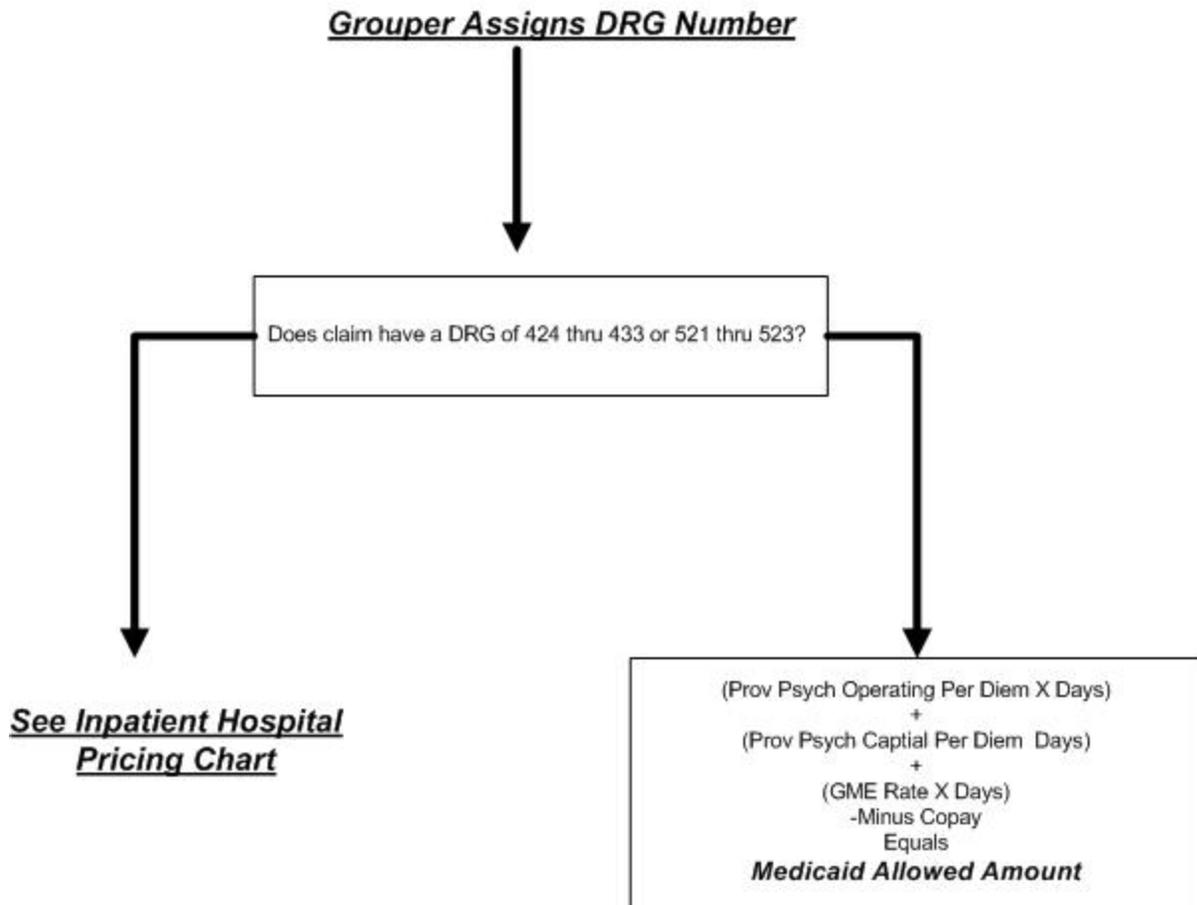
Inpatient Hospital Pricing/Transfer Out (TDOS After 10/14/2007)



Inpatient Hospital Pricing/Transfer to Post Acute (TDOS After 10/14/2007)



Inpatient Hospital Pricing (Psych DRGs)

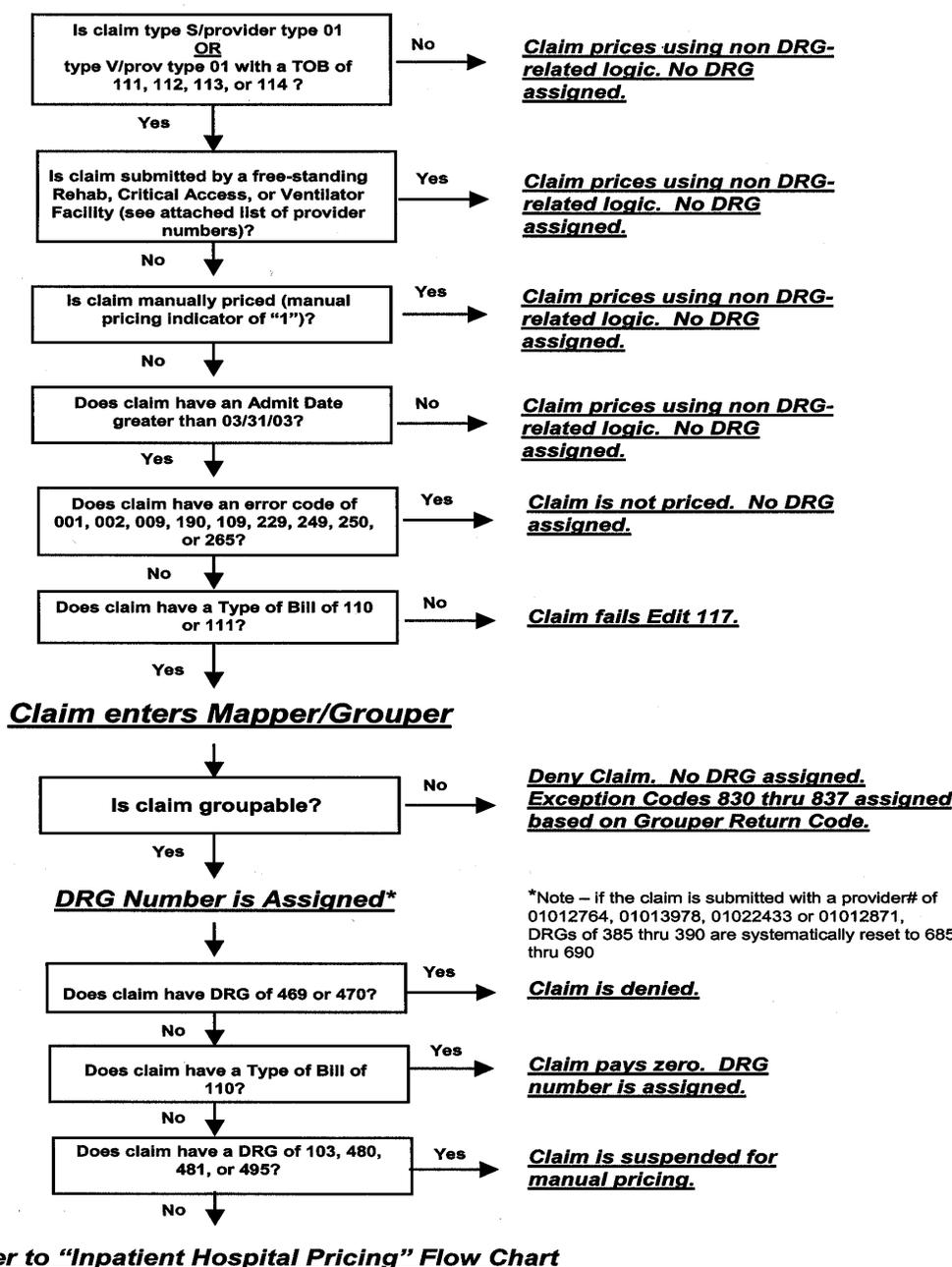


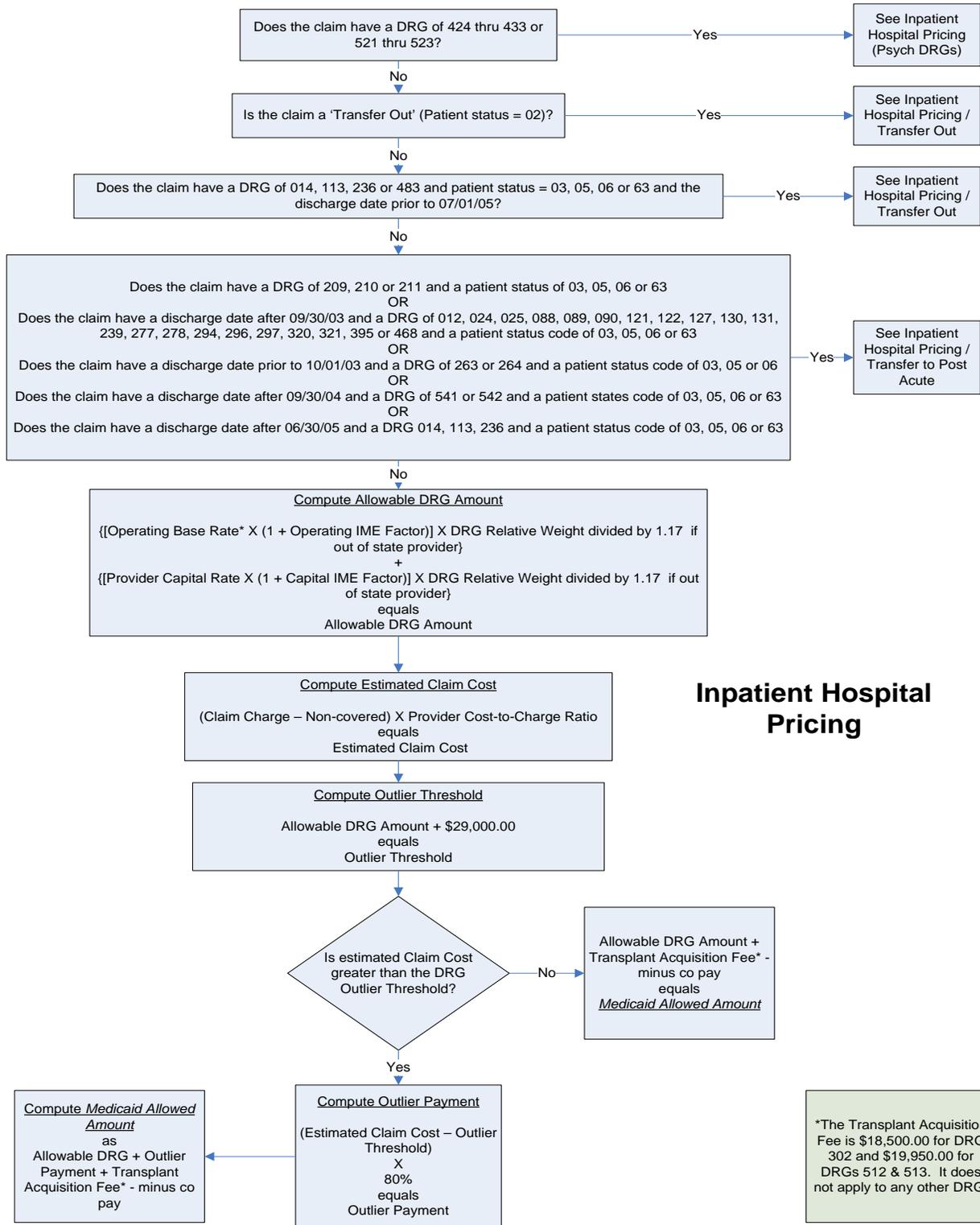
4.7.4 Claim Type I: Inpatient Hospital (PT-01) – DRG Pricing/TDOS Less Than 10/15/2007

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	HOSP NACIP (Non Acute Care Inpt) Critical Access, Rehab, and Ventilator	Reimbursement Classification	RC Inpatient DRG
Methodology/Logic	<p>Inpatient Hospital DRG Pricing claims will price using the pricing method: DRG (DRG) ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The DRG pricing method will pay the Diagnosis Related Groups (DRG) rate. The DRG rate can be found on the DRG rate panel.</p> <p>The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Inpatient hospital claims (including Part A crossovers), with the exception of the exclusions listed below, are reimbursed using the DRG (Diagnosis Related Groups) logic outlined in the flowcharts on the following pages. The Medicaid allowed amount is not compared to the billed amount. The reimbursement is the calculated allowed amount (less other insurance, spenddown, and copay, if any).</p> <p>An updated version of the DRG rates usually occurs in October or September of each calendar year. A “new” DRG version is used for the new period of time.</p> <p>DRG Pricing Exclusions</p> <p>Claims with an admit date prior to 04/01/03 are excluded from DRG pricing.</p> <p>Claims with a type of bill of 110 are assigned a DRG number but are not priced using the DRG logic. These claims pay zero. The ZEROPD pricing method is used and reimbursement rules exist to support this situation.</p>		

	<p>Manually priced claims are excluded from DRG pricing. The only inpatient hospital claims currently being manually priced are certain types of transplants.</p> <p>Claims submitted by critical access, freestanding rehab, and ventilator facilities are excluded from DRG pricing. These providers have their own provider contract.</p>
Exceptions	There are no exceptions.

DRG FLOW CHART

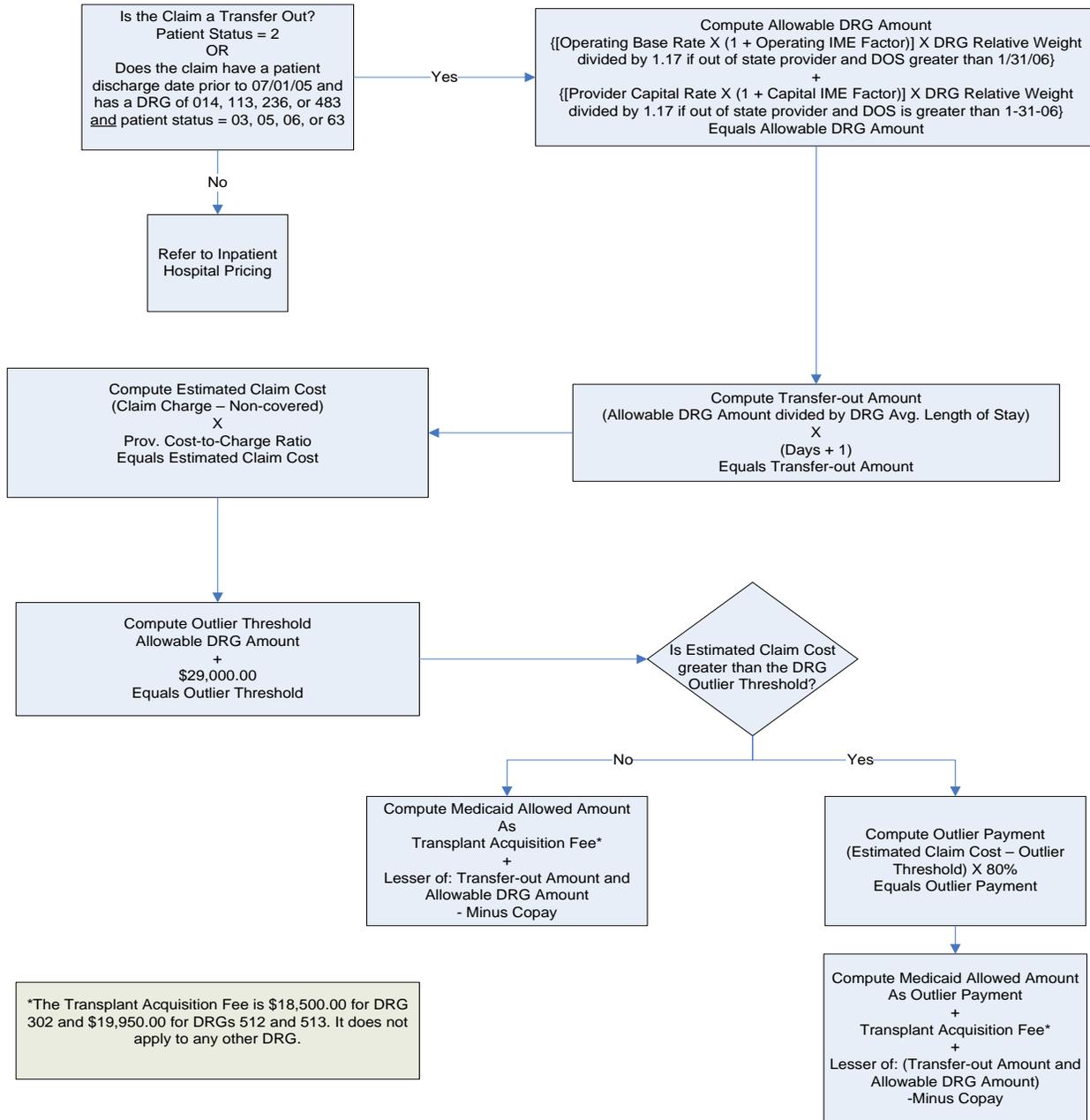




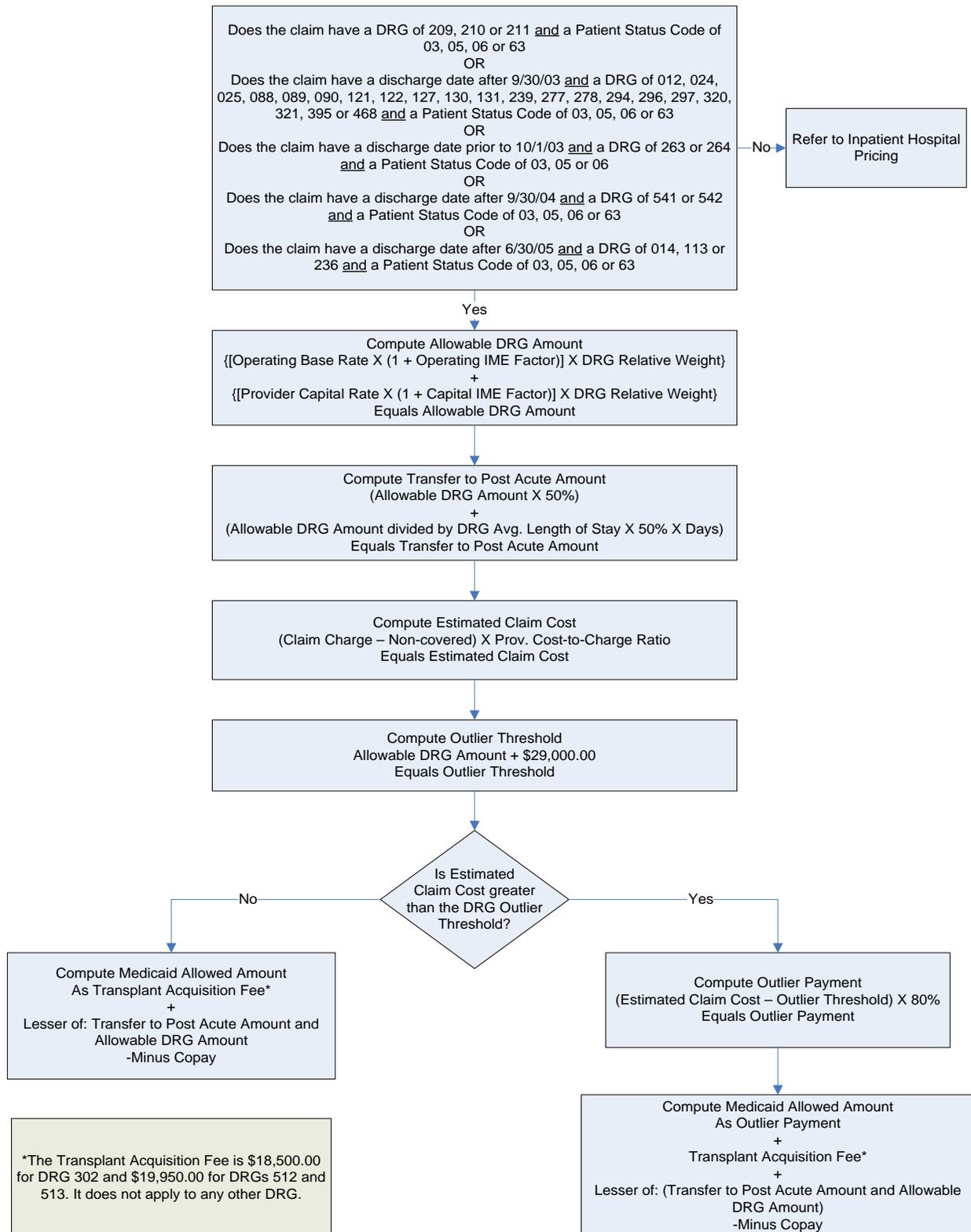
Inpatient Hospital Pricing

*The Transplant Acquisition Fee is \$18,500.00 for DRG 302 and \$19,950.00 for DRGs 512 & 513. It does not apply to any other DRG.

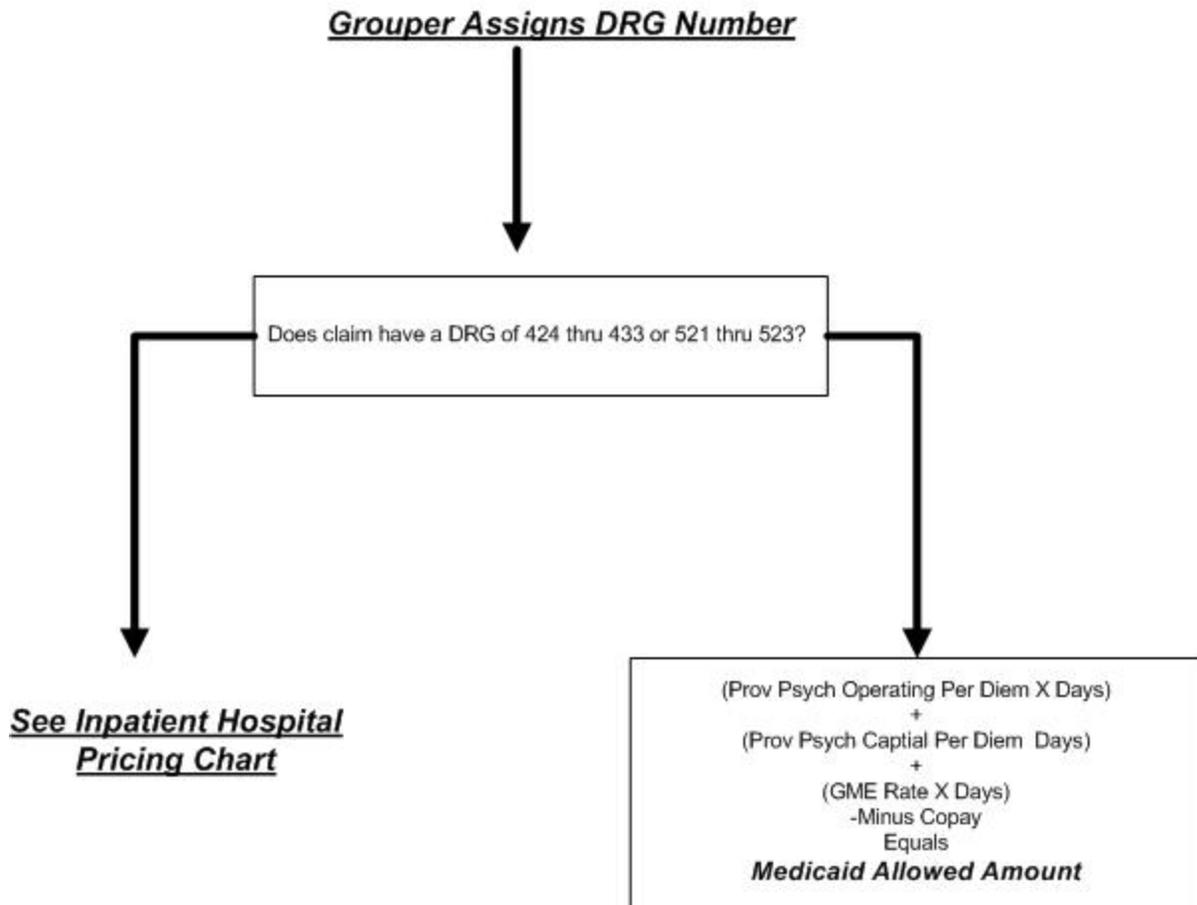
Inpatient Hospital Pricing/ Transfer Out



Inpatient Hospital Pricing/Transfer to Post Acute



Inpatient Hospital Pricing (Psych DRGs)



4.7.5 Claim Type I: Inpatient Hospital(PT-01)/Non-DRG/In-State/Disproportionate Share

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	HOSP NACIP (Non Acute Care Inpt) - Critical Access, Rehab, and Ventilator	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Inpatient Hospital (In-State/Disproportionate Share) claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem (DS1), (DS2) and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>Member Under Age 6*</u></p> <p>For claims with members under age 6* the facility's DSH per diem rate is multiplied by the number of covered days. The product of the DSH per diem rate times covered days is then added to the add-on fee (less other insurance, or spenddown, if any), is then subtracted to determine Medicaid reimbursement.</p> <p>Medicaid reimbursement =</p> <p>(DSH Per Diem Rate * Covered Days)</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>- Other Insurance</p> <p>- Spenddown</p> <p>*This methodology is only used if the member is under age 6, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for "Member Age 6 or Older" is used.</p>		

	<p><u>Member Age 6 or Older</u></p> <p>For claims with members age 6 and older the regular per diem rate for the date of service is multiplied by the number of covered days. The product of the per diem multiplied by covered days is added to the “add-on fee” and other insurance, spenddown, and copay, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Medicaid reimbursement =</p> <p>(DSH Per Diem Rate * Covered Days)</p> <p>+ (Add on Fee (ADD rate type) * Covered Days)</p> <p>- Other Insurance</p> <p>- Spenddown</p> <p>- Copay</p>
Exceptions	There are no exceptions.

4.7.6 Claim Type I: Inpatient Hospital (PT-01) / Non DRG-Related Claims – In - State/Non-Disproportionate Share

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	HOSP NACIP (Non Acute Care Inpt) Critical Access, Rehab, and Ventilator	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Inpatient Hospital (Non DRG-Related In-State/Non-Disproportionate Share claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>PMAXPD (Prov Max Per Diem)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem using various rate types and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>The PMAXPD (non DRG inpatient claims) pricing method will pay the provider maximum per diem using various rate types.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>Member Under age 1*</u></p> <p>For claims with members under age 1* the facility's regular per diem rate is multiplied by 110% and the product (of per diem * 110%) is multiplied by the number of covered days. This amount [(per diem * 110%) * covered days] is then added to the add-on fee and other insurance, if any, is then subtracted to determine Medicaid reimbursement.</p> <p>See the following formula:</p> <p>Medicaid Reimbursement =</p> <p>(Regular Per Diem Rate (IP1 rate type) *110%)</p> <p>* Covered days</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p>		

	<ul style="list-style-type: none"> - Other Insurance - Spenddown <p>*This methodology is only used if the member is under age 1, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for “Member Age 1 or Older” is used.</p> <p><u>Member Age 1 or Older</u></p> <p>For claims with members age 1 or older the regular per diem rate for the date of service is multiplied by the number of covered days. The product of the per diem multiplied by covered days is added to the add-on fee and other insurance, if any, is subtracted to determine Medicaid reimbursement.</p> <p>See the following formula:</p> <p>Medicaid Reimbursement =</p> <p>(Regular Per Diem Rate (IP1 rate type) * Covered Days)</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <ul style="list-style-type: none"> - Other Insurance - Copay - Spenddown
Exceptions	There are no exceptions.

4.7.3 Claim Type I: Inpatient Hospital (PT-01)/Non-DRG/Out-of State Hospitals – FDOS 09/01/2010 and After

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	NACIP (Non-Acute Care Inpt) - Critical Access, Rehab, and Ventilator	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Out-of-State Inpatient Hospital (non-DRG) claims with a From Date of Service of 09/01/2010 and after will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem (Rate Types IP1, DS1, DS2) plus the ‘add-on’ for accommodation revenue codes times covered days on the claim. Pricing does <u>not</u> cut back to the lesser of billed or allowed amount. TPL, Spenddown, and Copay are deducted, if applicable.</p> <p>Rate type IP1 is used for non-Disproportionate Share Hospitals. Rate types DS1 (non-DSH rate) and DS2 (DSH rate) are used for Disproportionate Share Hospitals. Rate Type ADD is used for the provider add-on rate.</p> <p>Note – Pricing of Out-of-State Hospital claims was changed to mirror in-state pricing per CO 14557.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info (Disproportionate Share Hospitals):</p> <p><u>Member Under Age 6*</u></p> <p>For claims submitted by Disproportionate Share Hospitals for members under age 6* the facility’s DSH per diem rate is multiplied by the number of covered days. The product of the DSH per diem rate times covered days is then added to the add-on fee (less other insurance, or spenddown, if any), is then subtracted to determine Medicaid reimbursement.</p> <p>Medicaid reimbursement =</p> <p>(DSH Per Diem Rate * Covered Days)</p>		

	<p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>- Other Insurance</p> <p>- Spenddown</p> <p>*This methodology is only used if the member is under age 6, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for “Member Age 6 or Older” is used.</p> <p><u>Member Age 6 or Older</u></p> <p>For claims with members age 6 and older the regular per diem rate for the date of service is multiplied by the number of covered days. The product of the per diem multiplied by covered days is added to the “add-on fee” and other insurance, spenddown, and copay, if any, is subtracted to determine Medicaid reimbursement.</p> <p>Medicaid reimbursement =</p> <p>(DSH Per Diem Rate * Covered Days)</p> <p>+ (Add on Fee (ADD rate type) * Covered Days)</p> <p>- Other Insurance</p> <p>- Spenddown</p> <p>- Copay</p>
Exceptions	There are no exceptions.

4.7.7 Claim Type I: Inpatient Hospital (PT-01)/Non DRG-Related Claims – Out-Of-State/Non-Disproportionate Share – FDOS Prior to 09/01/2010

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	HOSP NACIP (Non Acute Care Inpt) Critical Access, Rehab, and Ventilator	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Inpatient Hospital (Non DRG-Related Out-of-State/Non-Disproportionate Share claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>PMAXPD (Prov Max Per Diem)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem using various rate types and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>The PMAXPD (non DRG inpatient claims) pricing method will pay the provider maximum per diem using various rate types.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Out-of state non-disproportionate share Inpatient Hospital claims (other than Organ Transplants) are reimbursed at the header using provider rates maintained on the Provider Rate panel. Currently, each out-of-state, non-disproportionate share hospital will have a regular percentage rate, a disproportionate share (DSH) maximum per diem rate, and a regular maximum per diem rate.</p> <p>The DSH and regular maximum per diem rates are based on the number of beds (identified by various rate types) in the facility and the facility's out-of-state indicator (found on the provider's/facility's service location panel). In addition to these rates, some facilities also have an add-on fee rate.</p> <p>A list of the payment rate type for DSH and regular maximum per diem rates is located below (see tables), but can also be found in the reimbursement rules.</p> <p><u>Member Under Age 1*</u></p>		

For claims with members under age 1* the header net billed amount is multiplied by 85% (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of covered days is then multiplied by the DSH maximum per diem rate and the product (of covered days * DSH maximum per diem) is then compared to the product of the header net billed amount multiplied by 85%. The lesser of these two amounts (net billed * 85% or DSH maximum per diem * days) is added to the add-on fee and 75% of the professional component. Other insurance, spenddown, if any, is then subtracted to determine Medicaid reimbursement.

See the following formula:

Medicaid Reimbursement = THE LESSER OF:

[(85% * Net Billed Amount)]

OR

[(DSH Maximum Per Diem * Covered Days)]

+ (Add-on Fee (ADD rate type) * Covered Days)

+ 75% of Professional Component

- Other Insurance

- Spenddown

*This methodology is only used if the member is under age 1, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for “Claims with a Member Age 1 or Older” is used.

Member Age 1 or Older

For claims with members age 1 and older the regular percentage rate for the date of service is multiplied by the **header net billed amount** (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of covered days is then multiplied by the regular maximum per diem rate and the product (of covered days * maximum per diem) is then compared to the product of the header net billed amount multiplied by the regular percentage. The lesser of these two amounts (net billed * % or maximum per diem * days) is added to 75% of the professional component and the add-on fee * number of covered days. Other insurance, spenddown and copay, if any, are subtracted to determine Medicaid reimbursement.

See the following formula:

Medicaid Reimbursement = THE LESSER OF:

[(Regular % Rate * Net Billed Amount)]

OR

[(Regular Maximum Per Diem * Covered Days)]

+ (Add-on Fee (ADD rate type) * Covered Days)

+ 75% of Professional Component

- Other Insurance

- Spenddown

- Copay

The information below can be found within the reimbursement rules along with additional parameters:

INPATIENT HOSPITAL

REGULAR MAXIMUM PER DIEM PAYMENT MODES

Out-of-state Indicator	# of Beds in the Facility	Payment Mode
2 or 3	0 thru 50	IPA
2 or 3	51 thru 100	IPB
2 or 3	101 thru 200	IPC
2 or 3	201 thru 400	IPD
2 or 3	401 or greater	IPE
4	0 thru 50	IPK
4	51 thru 100	IPL
4	101 thru 200	IPM
4	201 thru 400	IPN
4	401 or greater	IPO

INPATIENT HOSPITAL

DSH MAXIMUM PER DIEM PAYMENT MODES

Out-of-state Indicator	# of Beds in the Facility	Payment Mode
2 or 3	0 thru 50	DSF

	2 or 3	51 thru 100	DSG
	2 or 3	101 thru 200	DSH
	2 or 3	201 thru 400	DSI
	2 or 3	401 or greater	DSJ
	4	0 thru 50	DSP
	4	51 thru 100	DSQ
	4	101 thru 200	DSR
	4	201 thru 400	DSS
	4	401 or greater	DST
Exceptions	There are no exceptions.		

4.7.8 Claim Type I: Inpatient Hospital (PT-01)/Non DRG-Related Claims – Out-Of-State/Disproportionate Share – FDOS Prior to 09/01/2010

Alpha Claim Type	I (formerly Legacy S)	Provider Type	01
Provider Contract	HOSP NACIP (Non Acute Care Inpt) Critical Access, Rehab, and Ventilator	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Inpatient Hospital (Non DRG-Related Out-of-State/Disproportionate Share claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>PMAXPD (Prov Max Per Diem)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem using various rate types and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>The PMAXPD (non DRG inpatient claims) pricing method will pay the provider maximum per diem using various rate types.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Out-of state disproportionate share (DSH) Inpatient Hospital claims are reimbursed at the header using provider rates maintained on the Provider Rate panel. Currently, each out-of-state DSH hospital will have both a regular percentage rate and a DSH percentage rate, a disproportionate share (DSH) maximum per diem rate, and a regular maximum per diem rate.</p> <p>The DSH and regular maximum per diem rates are based on the number of beds (identified by various rate types) in the facility and the facility's out-of-state indicator (found on the provider's/facility's service location panel). In addition to these rates, some facilities also have an add-on fee rate.</p> <p>A list of the payment rate type for DSH and regular maximum per diem rates is located below (see tables), but can also be found in the reimbursement rules.</p>		

	<p><u>Member Under Age 6*</u></p> <p>For claims with members under age 6* the facility's DSH percentage rate is multiplied by the header net billed amount (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of covered days is then multiplied by the DSH maximum per diem rate and the product (of covered days * DSH maximum per diem) is then compared to the product of the header net billed amount multiplied by the DSH percentage rate. The lesser of these two amounts [(net billed * DSH%) <u>or</u> (DSH maximum per diem * days)] is added to the add-on fee (mode "06" rate * number of covered days) and 75% of the professional component. Other insurance, spenddown, if any, is then subtracted to determine Medicaid reimbursement.</p> <p>See the following formula:</p> <p>Medicaid Reimbursement = THE LESSER OF:</p> <p>[(DSH % * Net Billed Amount)]</p> <p>OR</p> <p>[(DSH Maximum Per Diem * Covered Days)]</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>+ 75% of Professional Component</p> <p>- Other Insurance</p> <p>- Spenddown</p> <p>*This methodology is only used if the member is under age 6, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for "Member Age 6 or Older" is used.</p> <p><u>Member Age 6 or Older</u></p> <p>For claims with members age 6 and older the regular percentage rate for the date of service is multiplied by the header net billed amount (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of covered days is then multiplied by the regular maximum per diem rate and the product (of covered days * maximum per diem) is then compared to the product of the header net billed amount multiplied by the regular percentage. The lesser of these two amounts (net billed * % <u>or</u> maximum per diem * days) is added to 75% of the professional component and the add-on fee rate * number of covered days. Other insurance, spenddown and copay, if any, are subtracted to determine Medicaid reimbursement.</p>
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See the following formula:

Medicaid Reimbursement = THE LESSER OF:

[(Regular % Rate * Net Billed Amount)]

OR

[(Regular Maximum Per Diem * Covered Days)]

+ (Add-on Fee (ADD rate type) * Covered Days)

+ 75% of Professional Component

- Other Insurance

- Spenddown

- Copay

The information below can be found within the reimbursement rules along with additional parameters:

INPATIENT HOSPITAL

REGULAR MAXIMUM PER DIEM PAYMENT MODES

Out-of-state Indicator	# of Beds in the Facility	Payment Mode
2 or 3	0 thru 50	IPA
2 or 3	51 thru 100	IPB
2 or 3	101 thru 200	IPC
2 or 3	201 thru 400	IPD
2 or 3	401 or greater	IPE
4	0 thru 50	IPK
4	51 thru 100	IPL
4	101 thru 200	IPM
4	201 thru 400	IPN
4	401 or greater	IPO

INPATIENT HOSPITAL

DSH MAXIMUM PER DIEM PAYMENT MODES

Out-of-state Indicator	# of Beds in the Facility	Payment Mode
------------------------	---------------------------	--------------

	2 or 3	0 thru 50	DSF
	2 or 3	51 thru 100	DSG
	2 or 3	101 thru 200	DSH
	2 or 3	201 thru 400	DSI
	2 or 3	401 or greater	DSJ
	4	0 thru 50	DSP
	4	51 thru 100	DSQ
	4	101 thru 200	DSR
	4	201 thru 400	DSS
	4	401 or greater	DST
Exceptions	There are no exceptions.		

4.7.9 Claim Type I: Psychiatric Hospital (PT 02) (In-State/Non-Disproportionate Share)

Alpha Claim Type	I (formerly Legacy S)	Provider Type	02
Provider Contract	MENTH	Reimbursement Classification	RC Psych Hospital
Methodology/Logic	<p>Psychiatric Hospital (In-State/Non-Disproportionate Share) claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>PMAXPD (Prov Max Per Diem)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem using various rate types and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>The PMAXPD (non DRG inpatient claims) pricing method will pay the provider maximum per diem using various rate types.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>In-state non-disproportionate share Psychiatric Hospital claims are reimbursed at the header using provider rates maintained on the Provider Rate panel. Currently, each in-state non-disproportionate Psychiatric Hospital will have a regular per diem rate. Pricing logic exists to reimburse add-on fees to in-state Psychiatric Hospitals.</p> <p><u>Member Under Age 1*</u></p> <p>For claims with members under age 1* the facility’s regular per diem rate is multiplied by 110% and the product (of per diem * 110%) is multiplied by the number of covered days. This amount [(per diem * 110%) * covered days] is then added to the add-on fee and other insurance, if any, are then subtracted to determine Medicaid reimbursement.</p> <p>See the following formula:</p> <p>Medicaid Reimbursement =</p> <p>(Regular Per Diem Rate (IP1 rate type) * 110%)</p> <p>* Covered days</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p>		

	<ul style="list-style-type: none"> – Patient Liability – Other Insurance <p>*This methodology is only used if the member is under age 1, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for “Member Age 1 or Older” is used.</p> <p><u>Member Age 1 or Older</u></p> <p>For claims with members age 1 or older the regular per diem rate for the date of service is multiplied by the number of covered days. The product of the per diem multiplied by covered days is added to the add-on fee and patient liability and other insurance, if any, are subtracted to determine Medicaid reimbursement.</p> <p>See the following formula:</p> <p>Medicaid Reimbursement =</p> <p>(Regular Per Diem Rate (IP1 rate type) * Covered Days</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>– Patient Liability</p> <p>– Other Insurance</p>
Exceptions	There are no exceptions.

4.7.10 Claim Type I: Psychiatric Hospital (PT-02) In-State/Disproportionate Share

Alpha Claim Type	I (formerly Legacy S)	Provider Type	02
Provider Contract	MENTH	Reimbursement Classification	RC Psych Hospital
Methodology/Logic	<p>Psychiatric Hospital (In-State/Disproportionate Share) claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>PMAXPD (Prov Max Per Diem)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem using various rate types and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>The PMAXPD (non DRG inpatient claims) pricing method will pay the provider maximum per diem using various rate types.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>In-state disproportionate share (DSH) Psychiatric Hospital claims are reimbursed at the header using provider rates maintained on the Provider Rate panel. Currently, each in-state DSH Psychiatric Hospital will have both a regular per diem and a DSH per diem rate. Pricing logic exists to reimburse add-on fees to in-state Psychiatric Hospitals.</p> <p><u>Member Under Age 6*</u></p> <p>For claims with members under age 6* the facility's DSH per diem rate is multiplied by the number of covered days. The product of the DSH per diem rate * covered days is then added to the add-on fee and other insurance, if any, are then subtracted to determine Medicaid reimbursement.</p> <p>See the following formula:</p> <p>Medicaid Reimbursement =</p> <p>(DSH Per Diem Rate (DS2 rate type) * Covered Days)</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>– Patient Liability</p>		

	<p style="text-align: center;">– Other Insurance</p> <p>*This methodology is only used if the member is under age 6, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for “Member Age 6 or Older” is used.</p> <p><u>Member Age 6 or Older</u></p> <p>For claims with members age 6 and older the regular per diem rate for the date of service is multiplied by the number of covered days. The product of the per diem multiplied by covered days is added to the add-on fee and patient liability and other insurance, if any, are subtracted to determine Medicaid reimbursement.</p> <p>See the following formula:</p> <p>Medicaid Reimbursement =</p> <p>(Regular Per Diem Rate (DS1 rate type) * Covered Days)</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>– Patient Liability</p> <p>– Other Insurance</p>
Exceptions	There are no exceptions.

4.7.11 Claim Type I: Psychiatric Hospital (PT-02) Out-Of-State/Non-Disproportionate Share

Alpha Claim Type	I (formerly Legacy S)	Provider Type	02
Provider Contract	MENTH	Reimbursement Classification	RC Psych Hospital
Methodology/Logic	<p>Psychiatric Hospital (Out-of-State/Non-Disproportionate Share) claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>PMAXP (Prov Max Per Diem)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem using various rate types and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>The PMAXP (non DRG inpatient claims) pricing method will pay the provider maximum per diem using various rate types.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Out-of state non-disproportionate share Psychiatric Hospital claims are reimbursed at the header using provider rates maintained on the Provider Rate panel. Currently, each out-of-state, non-disproportionate share Psychiatric Hospital will have a regular percentage rate, a disproportionate share (DSH) maximum per diem rate, and a regular maximum per diem rate.</p> <p>The DSH and regular maximum per diem rates are based on the number of beds (identified by various rate types) in the facility and the facility's out-of-state indicator (found on the provider's/facility's service location panel). In addition to these rates, some facilities also have an add-on fee rate.</p> <p>A list of the payment rate type for DSH and regular maximum per diem rates is located below (see tables), but can also be found in the reimbursement rules.</p> <p><u>Member Under Age 1*</u></p> <p>For claims with members under age 1* the header net billed amount is multiplied by 85% (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of covered days is then</p>		

multiplied by the DSH maximum per diem rate and the product (of covered days * DSH maximum per diem) is then compared to the product of the header net billed amount multiplied by 85%. The lesser of these two amounts (net billed * 85% or DSH maximum per diem * days) is added to the add-on fee and 75% of the professional component. Patient liability and other insurance, if any, are then subtracted to determine Medicaid reimbursement.

See the following formula:

Medicaid Reimbursement = THE LESSER OF:

[(85% * Net Billed Amount)]

OR

[(DSH Maximum Per * Covered Days)]

+ (Add-on Fee (ADD rate type) * Covered Days)

+ 75% of Professional Component

– Patient liability

– Other Insurance

*This methodology is only used if the member is under age 1, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for “Member Age 1 or Older” is used.

Member Age 1 or Older

For claims with members age 1 and older the regular percentage rate for the date of service is multiplied by the **header net billed amount** (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of covered days is then multiplied by the regular maximum per diem rate and the product (of covered days * maximum per diem) is then compared to the product of the header net billed amount multiplied by the regular percentage. The lesser of these two amounts (net billed * % or maximum per diem * days) is added to 75% of the professional component and the add-on fee (ADD rate type * number of covered days). Patient liability and other insurance, if any, are subtracted to determine Medicaid reimbursement.

See the following formula:

Medicaid Reimbursement = THE LESSER OF:

[(Regular % Rate * Net Billed Amount)]

	<p>OR</p> <p>[(Regular Maximum Per Diem * Covered Days)]</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>+ 75% of Professional Component</p> <p>– Patient Liability</p> <p>– Other Insurance</p> <p>The information below can be found within the reimbursement rules along with additional parameters:</p> <p style="text-align: center;">PSYCHIATRIC HOSPITAL</p> <p style="text-align: center;"><u>REGULAR</u> MAXIMUM PER DIEM PAYMENT MODES</p> <table border="1" data-bbox="602 800 1349 957"> <thead> <tr> <th>Out-of-state Indicator</th> <th>PaymentMode</th> </tr> </thead> <tbody> <tr> <td>2 or 3</td> <td>IPU</td> </tr> <tr> <td>4</td> <td>IPX</td> </tr> </tbody> </table> <p style="text-align: center;">PSYCHIATRIC HOSPITAL</p> <p style="text-align: center;"><u>DSH</u> MAXIMUM PER DIEM PAYMENT MODES</p> <table border="1" data-bbox="597 1115 1354 1272"> <thead> <tr> <th>Out-of-state Indicator</th> <th>Payment Mode</th> </tr> </thead> <tbody> <tr> <td>2 or 3</td> <td>DSV</td> </tr> <tr> <td>4</td> <td>DSX</td> </tr> </tbody> </table>	Out-of-state Indicator	PaymentMode	2 or 3	IPU	4	IPX	Out-of-state Indicator	Payment Mode	2 or 3	DSV	4	DSX
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2 or 3	IPU												
4	IPX												
Out-of-state Indicator	Payment Mode												
2 or 3	DSV												
4	DSX												
<p>Exceptions</p>	<p>There are no exceptions.</p>												

4.7.12 Claim Type I: Psychiatric Hospital (PT-02) Out-Of-State/Disproportionate Share

Alpha Claim Type	I (formerly Legacy S)	Provider Type	02
Provider Contract	MENTH	Reimbursement Classification	RC Psych Hospital
Methodology/Logic	<p>Psychiatric Hospital (Out-of-State/Disproportionate Share) claims will price using the pricing method:</p> <p>PDDADD (Per Diem Add On)</p> <p>PMAXP (Prov Max Per Diem)</p> <p>Pricing Method(s):</p> <p>The PPDADD pricing method will pay the provider per diem using various rate types and the add on for accommodation revenue codes times covered days on the claim. Does not cutback to the lesser of billed or allowed amount.</p> <p>The PMAXP (non DRG inpatient claims) pricing method will pay the provider maximum per diem using various rate types.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Out-of state disproportionate share (DSH) Psychiatric Hospital claims are reimbursed at the header using provider rates maintained on the Provider Rate panel. Currently, each out-of-state DSH Psychiatric Hospital will have both a regular percentage rate and a DSH percentage rate, a disproportionate share (DSH) maximum per diem rate, and a regular maximum per diem rate.</p> <p>The DSH and regular maximum per diem rates are based on the number of beds (identified by various rate types) in the facility and the facility's out-of-state indicator (found on the provider's/facility's service location panel). In addition to these rates, some facilities also have an add-on fee rate.</p> <p>A list of the payment rate type for DSH and regular maximum per diem rates is located below (see tables), but can also be found in the reimbursement rules.</p> <p><u>Member Under Age 6*</u></p> <p>For claims with members under age 6* the facility's DSH percentage rate is multiplied by the header net billed amount (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of</p>		

covered days is then multiplied by the DSH maximum per diem rate and the product (of covered days * DSH maximum per diem) is then compared to the product of the header net billed amount multiplied by the DSH percentage rate. The lesser of these two amounts [(net billed * DSH%) or (DSH maximum per diem * days)] is added to the (add-on fee * number of covered days) and 75% of the professional component. Patient liability and other insurance, if any, are then subtracted to determine Medicaid reimbursement.

See the following formula:

Medicaid reimbursement = THE LESSER OF:

[(DSH% * Net Billed Amount)]

OR

[(DSH Maximum Per Diem * Covered Days)]

+ (Add-on Fee (ADD rate type) * Covered Days)

+ 75% of Professional Component

– Patient Liability

– Other Insurance

*This methodology is only used if the member is under age 6, the FDOS is after 6/30/1991, and the FDOS is more than 30 days greater than the admit date. If all three of these conditions are not met, the methodology for “Member Age 6 or Older” is used.

Member Age 6 or Older

For claims with members age 6 and older the regular percentage rate for the date of service is multiplied by the **header net billed amount** (The header net bill amount is determined by subtracting the total non-covered amount and total professional component from the total billed amount). The number of covered days is then multiplied by the regular maximum per diem rate and the product (of covered days * maximum per diem) is then compared to the product of the header net billed amount multiplied by the regular percentage. The lesser of these two amounts (net billed * % or maximum per diem * days) is added to 75% of the professional component and the add-on fee (rate * number of covered days). Patient liability and other insurance, if any, are subtracted to determine Medicaid reimbursement.

See the following formula:

Medicaid Reimbursement = THE LESSER OF:

	<p>[(Regular % Rate * Net Billed Amount)]</p> <p>OR</p> <p>[(Regular Maximum Per Diem * Covered Days)]</p> <p>+ (Add-on Fee (ADD rate type) * Covered Days)</p> <p>+ 75% of Professional Component</p> <p>– Patient Liability</p> <p>– Other Insurance</p> <p>The information below can be found within the reimbursement rules along with additional parameters:</p> <p style="text-align: center;">PSYCHIATRIC HOSPITAL</p> <p style="text-align: center;"><u>REGULAR</u> MAXIMUM PER DIEM PAYMENT MODES</p> <table border="1" data-bbox="550 856 1399 1012"> <thead> <tr> <th>Out-of-state Indicator</th> <th>Payment Mode</th> </tr> </thead> <tbody> <tr> <td>2 or 3</td> <td>IPU</td> </tr> <tr> <td>4</td> <td>IPX</td> </tr> </tbody> </table> <p style="text-align: center;">PSYCHIATRIC HOSPITAL</p> <p style="text-align: center;"><u>DSH</u> MAXIMUM PER DIEM PAYMENT MODES</p> <table border="1" data-bbox="550 1243 1399 1398"> <thead> <tr> <th>Out-of-state Indicator</th> <th>Payment Mode</th> </tr> </thead> <tbody> <tr> <td>2 or 3</td> <td>DSV</td> </tr> <tr> <td>4</td> <td>DSX</td> </tr> </tbody> </table>	Out-of-state Indicator	Payment Mode	2 or 3	IPU	4	IPX	Out-of-state Indicator	Payment Mode	2 or 3	DSV	4	DSX
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2 or 3	IPU												
4	IPX												
Out-of-state Indicator	Payment Mode												
2 or 3	DSV												
4	DSX												
Exceptions	There are no exceptions.												

4.7.13 **Claim Type I: Psychiatric Hospital (PT-02) Eating Disorder – Provider Contract RDGBH**

Alpha Claim Type	I (formerly Legacy S)	Provider Type	02
Provider Contract	RDGBH	Reimbursement Classification	Rdg Behav Eating Dis
Methodology/Logic	<p>Psychiatric Hospital Eating Disorder claims will price using the pricing method:</p> <p>PPRUNT (Provider Priced Unit)</p> <p>Pricing Method(s):</p> <p>The PPRUNT pricing method will get the provider's specific rate using the PED rate type for the date of service on the claim (detail). The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.7.14 Claim Type I: Psychiatric Residential Treatment Facility (PRTF) (PT 04)

Alpha Claim Type	I (formerly Legacy S)	Provider Type	04
Provider Contract	PRTF	Reimbursement Classification	RC Psych RTF
Methodology/Logic	<p>Psychiatric Residential Treatment Facility claims will price using the pricing method:</p> <p>PPRUNL (Provider Priced Unit)</p> <p>ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The PPRUNL pricing method will get the provider's specific rate using the PED rate type for the date of service on the claim (detail). The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.7.15 Claim Type I: Psychiatric Distinct Part Unit (PT 92)

Alpha Claim Type	I (formerly Legacy S)	Provider Type	92
Provider Contract	PYDPU	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Psychiatric Distinct part Unit claims will price using the pricing method: PPRUNT (Provider Priced Unit) ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The PPRUNT pricing method will get the provider's specific rate using the DEF rate type for the date of service on the claim (detail). The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.7.16 Claim Type I: Rehabilitation Distinct Part Unit (PT 93)

Alpha Claim Type	I (formerly Legacy S)	Provider Type	93
Provider Contract	RHDPU	Reimbursement Classification	RC Inpatient Hospita
Methodology/Logic	<p>Rehabilitation Distinct part Unit claims will price using the pricing method:</p> <p>PPRUNT (Provider Priced Unit)</p> <p>ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The PPRUNT pricing method will get the provider's specific rate using the DEF rate type for the date of service on the claim (detail). The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.8 Claim Type L

4.8.1 Claim Type L: Intermediate Care Facility/Mental Retardation (ICF/MR) (Prov Type 11)

Alpha Claim Type	L (formerly Legacy T)	Provider Type	11
Provider Contract	ICFMR	Reimbursement Classification	RC ICF/MR
Methodology/Logic	<p>ICF/MR claims will price using the pricing method:</p> <p>PPRUNT (Provider Priced Unit)</p> <p>PPRPCT (Provider Priced Percent)</p> <p>Pricing Method(s):</p> <p>The PPRUNT pricing method will get the provider's specific rate using the (MR1) rate type for the date of service on the claim (detail). The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>The PPRPCT pricing method will get the provider's specific percentage rate using the (MR2) rate type for the date of service on the claim (detail). The provider's specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>Default Pricing Logic: None.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.8.2 Claim Type L: Intermediate Care Facility (ICF) (Prov Type 11)

Alpha Claim Type	L (formerly Legacy T)	Provider Type	11
Provider Contract	ICFMR	Reimbursement Classification	RC ICF/MR
Methodology/Logic	<p>ICF/MR claims will price using the pricing method:</p> <p>PPRUNT (Provider Priced Unit)</p>		

	<p>PPRPCT (Provider Priced Percent)</p> <p>Pricing Method(s):</p> <p>The PPRUNT pricing method will get the provider’s specific rate using the (MR1) rate type for the date of service on the claim (detail). The provider’s specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>The PPRPCT pricing method will get the provider’s specific percentage rate using the (MR2) rate type for the date of service on the claim (detail). The provider’s specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p>Default Pricing Logic: None.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.8.3 Claim Type L: Nursing Facility (Prov Type 12)

Alpha Claim Type	L (formerly Legacy T)	Provider Type	12
Provider Contract	NFAC NFCB (Cost Based)	Reimbursement Classification	RC Nursing Facility
Methodology/Logic	<p>Nursing Facility claims will price using the pricing method:</p> <p>PPRPCT (Provider Priced Percent)</p> <p>PPRUNT (Provider Priced Unit)</p> <p>PPCTUN (Provider Priced Unit With Percent)</p> <p>REVMXF (Revenue Max Fee)</p> <p>LTCDME (Oxygen/DME Rental Rates)</p> <p>Pricing Method(s):</p> <p>The PPRPCT pricing method is used for cost-based providers only (NFCB contract) and gets the provider’s specific percentage rate using the (NF2) rate type for the date of service on the claim (detail). The provider’s</p>		

specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).

*Note – the pricing methods below are used for providers other than cost-based and are applied based on the revenue code billed. See “**Additional Reimbursement Info**” later in this section for a description of which pricing method is applied to which revenue code(s).*

The PPRUNT pricing method will get the provider’s specific per diem rate using the (NF1) rate type for the date of service on the claim (detail). The provider’s specific per diem rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim line. This value is NOT compared to the billed amount. Reimbursement is the calculated allowed amount (less patient liability and other insurance, if any).

The PPCTUN pricing method will get the provider’s specific per diem rate and the percentage rate associated to that per diem using the (NF1) rate type for the date of service on the claim (detail). The provider’s specific per diem and percentage rates can be found on the Provider Rate panel for that provider. The per diem rate is multiplied by the percentage rate and the product (of per diem X percentage) is multiplied by the units on the claim line. This value is NOT compared to the billed amount. Reimbursement is the calculated allowed amount (less patient liability and other insurance, if any).

The REVMXF pricing method will get the Max Fee for the procedure code submitted with the revenue code on the claim detail. The Max Fee rate can be found on the Max Fee panel (Reference subsystem) using the rate type of (P4O), (PSO) for the date of service on the claim detail. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).

The LTCDME pricing method will get the Max Fee for the procedure code submitted with the revenue code on the claim detail. The Max Fee rate can be found on the Max Fee panel (Reference subsystem) using the rate type of (P90) for the date of service on the claim detail. The rate is not multiplied by the units of service. However, some additional rate calculations are also applied based on specific modifiers billed with the procedure codes. These are outlined in the “**Additional Reimbursement Info**” later in this section. Reimbursement is the lesser of the DME rental rate (with the modifier calculation applied, if applicable) or the billed amount.

Default Pricing Logic: None.

	<p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>If the service is Revenue Code 110, 120, 130, 140, 150, 160</u></p> <p>The PPRUNT pricing method and the NF1 rate type are used.</p> <p><u>If the service is Revenue Code 180, 185</u></p> <p>For dates of service 07/01/2005 and after, bed reserve days pay a percentage of the provider's per diem rate. The PPCTUN pricing method and the NF1 rate type (for both per diem and percentage rate) are used for dates of service 07/01/2005 and after.</p> <p>The PPRUNT pricing method and the NF1 rate type (per diem only) are used for dates of service prior to 07/01/2005.</p> <p><u>If the service is Revenue Code 300 - 314 (Lab and Pathology Services)</u></p> <p>AND the DOS is 11/1/2003 or after, these revenue codes must be billed with a valid lab or pathology procedure code (80000 – 89999). See the reimbursement rule for these services.</p> <p>For lab procedure codes the REVMXF pricing method and the PSO rate type are used.</p> <p>For pathology procedure codes the REVMXF pricing method and the P4O rate type are used.</p> <p>AND the DOS is prior to 11/01/2003, there is no requirement to bill with certain procedure codes. The PPRPCT pricing method and the NF2 rate type are used.</p> <p><u>If the service is Revenue Code 320 (X-ray Services)</u></p> <p>AND the DOS is 11/01/2003 or after, these revenue codes must be billed with certain X-ray procedure codes. See the reimbursement rule for these services. The REVMXF pricing method and the P4O rate type are used.</p> <p>AND the DOS is prior to 11/01/2003 there is no requirement to bill with certain procedure codes. The PPRPCT pricing method and the NF2 rate type are used.</p> <p><u>If the service is Revenue Code 410 (Oxygen Services)</u></p> <p>AND the DOS is 11/01/2003 or after, revenue code 410 requires the addition of a certain procedure code(s). These are E1390, E0450, E0424,</p>
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	<p>E0431, and E0434.</p> <p>Pricing of these revenue/procedure code combinations is based on the DME rental rate for the procedure code billed. These are contained on the Procedure Code Maxfee panel (rate type 'P90'). The rental rate is <u>not</u> multiplied by the units of service. If there is no rate on file, the detail allowed amount will be calculated as zero.</p> <p>If one of the following modifiers (set-up as a processing modifier) is submitted with revenue code 410, the rate will be multiplied by the following factors to determine Medicaid allowed amount:</p> <p>QE = 50% of rate</p> <p>QG = 150% of rate</p> <p>QF = 150% of rate plus \$30.67</p> <p>No more than two oxygen/revenue code 410 charges are payable per claim. One payment will be made for <u>either</u> procedure code E1390, E0450, <u>or</u> E0424 PLUS one payment will be made for <u>either</u> procedure code E0431 <u>or</u> E0434. Any additional oxygen charges than those described above will pay zero.</p> <p>AND the DOS is prior to 11/01/2003, there is no requirement to bill with certain procedure codes. The PPRPCT pricing method and the NF2 rate type are used.</p> <p><u>If the service is Revenue Code 420, 430, 440 (Therapy Services)</u></p> <p>AND the DOS is 11/1/2003 or after, these revenue codes must be billed with certain procedure codes. See the reimbursement rule for these services. The REVMXF pricing method and the P4O rate type are used.</p> <p>AND the DOS is prior to 11/01/2003, there is no requirement to bill with certain procedure codes. The PPRPCT pricing method and the NF2 rate type are used.</p> <p><u>Cost Based Providers (contract</u></p> <p>Cost based providers have their own specific provider contract and price using the PPRPCT pricing method with the NF2 rate type.</p>
Exceptions	There are no exceptions.

4.9 Claim Type M

4.9.1 Claim Type M: Commission For Handicapped Children (CHC) (Prov Type 22)

Alpha Claim Type	M (formerly Legacy E)	Provider Type	22
Provider Contract	CCSHC	Reimbursement Classification	Standard
Methodology/Logic	<p>CHC claims will price using the pricing method: PPRPCT (Provider Priced Percent)</p> <p>Pricing Method(s):</p> <p>The PPRPCT pricing method will get the provider's specific percentage rate using the (CHC) rate type for the date of service on the claim (detail). The provider's specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).</p> <p>Default Pricing Logic: None.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	<p>Procedure code V5264 will be reimbursed at a flat rate using rate type P50 per CO 14294.</p> <p>Procedure codes 97802 – 97804 will be reimbursed at a flat rate using rate type P40 per CO 14720.</p>		

4.9.2 Claim Type M: Early Intervention (Prov Type 24)

Alpha Claim Type	M (formerly Legacy E)	Provider Type	24
Provider Contract	FSTEP	Reimbursement Classification	RC Fst Step/Erly Int
Methodology/Logic	<p>Early Intervention claims will price using the pricing method: BILLED (Pay as Billed)</p> <p>Pricing Method(s):</p> <p>The BILLED pricing method will reimburse the detail billed amount on the claim (less copay, other insurance and spenddown, if any).</p> <p>Default Pricing Logic: None</p>		

	Pricing Method - Services which price from PA: None Additional Reimbursement Info: None
Exceptions	There are no exceptions.

4.9.3 Claim Type M: Hands (Prov Type 15)

Alpha Claim Type	M (formerly Legacy E)	Provider Type	15
Provider Contract	HANDS	Reimbursement Classification	RC HANDS
Methodology/Logic	<p>HANDS claims will price using the pricing method:</p> <p>MXFLT2 (Max Flat Fee II)</p> <p>MAXFLT (Max Flat Fee)</p> <p>Pricing Method(s):</p> <p>The MXFLT2 pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel for the rate type (MX2) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the rate obtained for the service. The obtained rate is not compared to the billed amount on the detail.</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel for the rate type (MX2) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount.</p> <p>Pricing Method (10/30/2002 – 12/31/2299):</p> <p>The MXFLT2 pricing method is used for all services.</p> <p>Pricing Method (Prior to and on 10/29/2002):</p> <p>The MAXFLT pricing method is used for all services.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.9.4 Claim Type M: Impact Plus (Prov Type 29)

Alpha Claim Type	M (formerly Legacy E)	Provider Type	29
Provider Contract	IPLUS	Reimbursement Classification	RC Impact Plus
Methodology/Logic	<p>Impact Plus claims will price using the pricing method: LPABIL (Lesser of PA or Bill Amt)</p> <p>Pricing Method(s):</p> <p>Services will have a “Y” PA indicator on the provider contract for the provider (Impact Plus). The LPABIL pricing method will be used. This compares the PA amount versus the Max Fee for the service (i.e. procedure code). The reimbursement is determined by comparing the detail billed amount to the prior authorized amount listed on the Prior Authorization file. The reimbursement is the lesser of the two (less other insurance and spenddown, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: All</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.9.5 Claim Type M: Preventive Health Services (Prov Type 20)

Alpha Claim Type	M (formerly Legacy E)	Provider Type	20
Provider Contract	PREVH	Reimbursement Classification	RC Prev Health
Methodology/Logic	<p>Preventive Health Service claims will price using the pricing method: MAXFLT (Max Flat Fee) MAXFEE (Max Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (P8O), (P4O), (DEF), (PSO) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance and spenddown, if any).</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (P4O), (P8O), (PH1), (PH2), (PH3) for the date of service (from the claim). The rate is</p>		

	<p>multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).</p> <p>Pricing Method (Dates of Service 7/1/2007 – 12/31/2299):</p> <p>The MAXFEE pricing method will be used for all procedure codes using the P8O rate type effective with dates of service 7/01/2007 per change order 12294.</p> <p>Pricing Method (Dates of Service 7/1/2005 – 6-30-2007):</p> <p>The MAXFLT pricing method with rate type P8O is used for all services with the exception of S4993, A4267, 82962, and 97803. These codes were changed to MAXFEE per CO 10727 effective for dates of service 01/01/2008.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be performed. The reimbursement is 0% of the billed amount.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p>Pricing Method (Date of Service 7/1/2003 - 6/30/2005):</p> <p>The MAXFLT pricing method with rate type P4O is used for all procedures with the exception of Lab codes, procedure codes 97802 and 97803, and procedure codes billed with a TC or 26 modifier.</p> <p>The MAXFLT pricing method with rate type PSO is used for all Lab procedure codes (80000-89999).</p> <p>The MAXFEE pricing method with rate type P4O is used for procedure codes 97802 and 97803.</p> <p>The MAXFLT pricing method with rate type DEF is used for procedure codes submitted in conjunction with modifier TC or 26.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>For claims within this time frame (7/1/2003 - 6/30/2005), once the appropriate rate is determined it is multiplied by a 'performing professional' rate factor based on the modifiers listed below.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="background-color: #ffff00;">MODIFIER</th> <th style="background-color: #ffff00;">RATE FACTOR</th> </tr> </thead> <tbody> <tr> <td>AM (Physician)</td> <td>100%</td> </tr> <tr> <td>SA (ARNP)</td> <td>75%</td> </tr> <tr> <td>U1 (PA)</td> <td>75%</td> </tr> </tbody> </table>	MODIFIER	RATE FACTOR	AM (Physician)	100%	SA (ARNP)	75%	U1 (PA)	75%
MODIFIER	RATE FACTOR								
AM (Physician)	100%								
SA (ARNP)	75%								
U1 (PA)	75%								

TD (RN)	60%
TE (LPN)	60%

To determine Medicaid reimbursement, multiply the procedure rate by the appropriate rate factor and compare the product (of rate X rate factor) to the detail billed amount. Medicaid reimbursement is the lesser of the two (less other insurance and spend down, if any).

The combination of the service (i.e. procedure code), modifier(s), modifier override type value, rate type, and Benefit Adjustment Factor (BAF) will determine the reimbursement rule used for the reimbursement.

Example(s):

Procedure code = 97802; modifier = AM and no 26 or TC modifier, the rule with rate type P4O will be used.

Procedure code = 97802; modifier = SA or U1 and no 26 or TC modifier, the rule with rate type P4O will be used with a Benefit Adjustment Factor (BAF) of 75%.

Procedure code = 97802; modifier = TD or TE and no 26 or TC modifier, the rule with rate type P4O will be used with a Benefit Adjustment Factor (BAF) of 65%

Pricing Method (Prior to and on 6/30/2003):

The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (PH1), (PH2), (PH3), (MX1) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).

Default Pricing Logic: None

Pricing Method - Services which price from PA: None

Additional Reimbursement Info:

For claims within this time frame (Prior to and on 6/30/2003), the combination of the service (i.e. procedure code), modifier(s), modifier override type value, rate type will determine the reimbursement rule used for the reimbursement.

Example(s):

Procedure code = 99211; modifier = A1, A2, A3, A4, B1,C1, J1, J2, K1, K2, K3, K4, L1, or M1 and the modifier type is overridden to pricing, the rule with rate type PH1 will be used.

If we have the same procedure, but a modifier = B1, C2, C3, E1, E2, L2, M2 or M3 and the modifier type is overridden to pricing, the rule with rate

	<p>type PH2 will be used.</p> <p>If we have the same procedure, but a modifier = C4 or M4 and the modifier type is overridden to pricing, the rule with rate type PH3 will be used.</p> <p>If we have the same procedure, but a modifier = C4 or M4 and the modifier type is overridden to pricing, the rule with rate type PH3 will be used.</p>
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4.9.6 Claim Type M: School Based Health Services (Prov Type 21)

Alpha Claim Type	M (formerly Legacy E)	Provider Type	21
Provider Contract	SBHS	Reimbursement Classification	RC Schl Base Service
Methodology/Logic	<p>For this provider type, the specific service performed will determine which pricing method is used for the claim.</p> <p><u>If the service is (procedure code):</u></p> <p>90887, 96150, 97533, 99199 or T1013 then the MAXFEE (Max Fee) and a rate type of SBS (School Based Svcs) is used. Also, included are old KY local codes X0001, X0002, X0058, XH100 (prior to and on 10/15/2003). Procedure codes H0031 and H0032 added effective 8/5/2011 per CO 16414.</p> <p>Pricing Method (all dates of service):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code and modifier combination) from the Max Fee panel, for the rate type (SBS) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The Federal Match rate, which can be found on the Fund Code Rate panel (Financial), is applied to the lesser of the two and this becomes the reimbursement (less other insurance and spenddown, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p><u>If the service is (procedure code):</u></p> <p>92508, 96153, 97530, or 97110 then SBGRP (School Base Group) and a rate type of SBS (School Based Svcs) is used. Also, included are old KY</p>		

	<p>local codes X0081, X0082, X0083, X0084 (prior to and on 10/15/2003).</p> <p>Pricing Method (all dates of service):</p> <p>The SBGRP pricing method will obtain the rate for the service (i.e. procedure code and modifier combination) from the Max Fee panel, for the rate type (SBS) for the date of service (from the claim). The rate is multiplied by the units of service on the detail divided by the number of students in the session. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>Note: Units will be billed in 15 minute increments for these procedure codes.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p><u>If the service is (procedure code):</u></p> <p>A0160 then the MAXFEE (Max Fee) and a rate type of MX1 (MAX FLAT FEE 1) is used.</p> <p>Pricing Method (all dates of service):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (MX1) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount.</p> <p>Note: Units for A0160 will be billed in number of miles.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p><u>If the service is (procedure code):</u></p> <p>E1399 then MANUAL (Manual) and a rate type of NA (Not Applicable) is used. Also, included are old KY local codes X0099 (prior to and on 10/15/2003).</p> <p>Pricing Method (all dates of service):</p> <p>The MANUAL pricing method will be used for this service. The</p>
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	<p>Resolutions unit will pay the amount on the attached invoice. The Federal Match rate, which can be found on the Fund Code Rate panel (Financial) is then applied and this becomes the reimbursement.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions

4.9.7 Claim Type M: Title V/DSS (Prov Type 23)

Alpha Claim Type	M (formerly Legacy E)	Provider Type	23
Provider Contract	TVDDS	Reimbursement Classification	RC TitleV/DSS
Methodology/Logic	<p>For this provider type, the specific service performed will determine which pricing method is used for the claim.</p> <p><u>If the service is (procedure code):</u></p> <p>99199, 99244, 99245, H0043, H2012, T1025, or T2023, then the UCCFL2 (UCC Flat Fee II) pricing method and a rate type of (TV1 - Title V PPR1) is used. Also, included are old KY local codes X0064, X0073, X0088 (prior to and on 10/15/2003).</p> <p>Pricing Method (all dates of service):</p> <p>The UCCFL2 pricing method will obtain the provider specific rate from the Customary Charge panel (Provider) for the date of service. The rate is not multiplied by the units on the detail. The rate is not compared to the billed amount. The reimbursement is the rate obtained for the specific provider.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p><u>If the service is (procedure code):</u></p> <p>90804, 90853, 90887, H2021, H2019 or T1023, then the LPABIL (Lesser of PA or Bill Amt) pricing method and a rate type of (NA - Not Applicable) is used. Also, included are old KY local codes X0050, X0051, X0058, X0060, X0086, XH100 (prior to and on 10/15/2003).</p> <p>Pricing Method (all dates of service):</p>		

	<p>Services will have a “Y” PA indicator on the provider contract for the provider (TitleV/DSS). The LPABIL will be used. This compares the PA amount versus the Max Fee for the service (i.e. procedure code). The reimbursement is determined by comparing the detail billed amount to the prior authorized amount listed on the Prior Authorization file. The reimbursement is the lesser of the two (less other insurance and spenddown, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: 90804, 90853, 90887, H2021, H2019 or T1023</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.8 Claim Type M: Adult Targeted Case Management (Prov Type 27)

Alpha Claim Type	M (formerly Legacy G)	Provider Type	27
Provider Contract	ATCM	Reimbursement Classification	Standard
Methodology/Logic	<p>Adult Targeted Case Management claims will price using the pricing method:</p> <p>LMXUCC (Lesser of Max Fee or UCC)</p> <p>MAXFLT (Max Flat Fee)</p> <p>Pricing Method(s):</p> <p>The LMXUCC pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (MX2) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. Then it obtains the provider’s specific rate for the service (i.e. procedure code) from the Customary Charge panel (Provider) for the date of service. The reimbursement is the lesser of the two (less other insurance and spenddown, if any).</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (MX2) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance and spenddown, if any).</p> <p>Pricing Method (1/1/2003 – 12/31/2299):</p> <p>The LMXUCC pricing method is used for all services.</p> <p>Default Pricing Logic: None</p>		

	<p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p>Pricing Method (Prior to and on 12/31/2002): The MAXFLT pricing method is used for all services.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.9 Claim Type M: Children Targeted Case Management (Prov Type 28)

Alpha Claim Type	M (formerly Legacy G)	Provider Type	28
Provider Contract	CTCM	Reimbursement Classification	Standard
Methodology/Logic	<p>Child Targeted Case Management claims will price using the pricing method:</p> <p>LMXUCC (Lesser of Max Fee or UCC)</p> <p>MAXFLT (Max Flat Fee)</p> <p>Pricing Method(s):</p> <p>The LMXUCC pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (MX1) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. Then it obtains the provider's specific rate for the service (i.e. procedure code) from the Customary Charge panel (Provider) for the date of service. The reimbursement is the lesser of the two (less other insurance and spenddown, if any).</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (MX1) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance and spenddown, if any).</p> <p>Pricing Method (1/1/2003 – 12/31/2299):</p> <p>The LMXUCC pricing method is used for all services.</p> <p>Default Pricing Logic: None</p>		

	<p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p>Pricing Method (Prior to and on 12/31/2002): The MAXFLT pricing method is used for all services.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.10 Claim Type M: Specialized Children’s Special Service Clinics (Prov Type 13)

Alpha Claim Type	M (formerly Legacy J)	Provider Type	13
Provider Contract	SCSVC	Reimbursement Classification	Standard
Methodology/Logic	<p>Specialized Children’s Special Service Clinic claims will price using the pricing method:</p> <p>MAXFLT (Max Flat Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (MX2) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance and spenddown, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p>Note: This Provider Type is only reimbursed for the Procedure Code 99499.</p>		
Exceptions	There are no exceptions.		

4.9.11 Claim Type M: Physician (Prov Type 64/65)

DMS Approved 07/08/2012

Alpha Claim Type	M (formerly Legacy J)	Provider Type	64/65
DOS Effective	01/01/04	Adjudication Date Effective	
Provider Contract	PHYS	Reimbursement Classification	RC Professional Svcs
Methodology/Logic	<p>Physician claims, with the exception of “Brown Bagging” drugs (discussed later in this section), will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>MAXFLT (Max Flat Fee)</p> <p>ANESTH (Anesthesia)</p> <p>Pricing Method(s):</p> <p>The <u>MAXFEE pricing method</u> will obtain the rate for the service (i.e. procedure code and/or modifier combination) from the Max Fee panel for the rate type, for the claim date of service. The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay amount and other insurance and spenddown, if any).</p> <p>Unless indicated otherwise later in this section, rate type P4I is used for procedure codes (other than Lab) billed with a place of service code of 21, 24, 51, 61, or 62. Rate type P4O is used for procedure codes (other than Lab) billed with a place of service code other than 21, 24, 51, 61, or 62.</p> <p>Note - If a rate is not found for the procedure code for the date of service or if the applicable rate has an amount of zero, default pricing logic (explained later in this section) will be performed.</p> <p>The <u>MAXFLT pricing method</u> will obtain the rate for the service (i.e. procedure code) from the Max Fee panel for the rate type, for the date of service (from the claim). For this pricing method the rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance and spenddown, if any).</p> <p>Unless indicated otherwise later in this section, rate type P4I is used for procedure codes billed with a place of service code of 21, 24, 51, 61, or 62. Rate type P4O is used for procedure codes billed with a place of service code other than 21, 24, 51, 61, or 62.</p> <p>Note - If a rate is not found for the procedure code for the date of service or if the applicable rate has an amount of zero, default pricing logic (explained later in this section) will be performed.</p>		

<p>The <u>ANESTH pricing method</u> will obtain a base rate (rate type = ANE) and ASA Relative Value units for the procedure code from the Max Fee panel for the procedure code/date of service and apply the following formula:</p> <p>Base Rate X [(ASA RVU* + (Units of Service / 15)) = Medicaid Allowed Amount.</p> <p>Medicaid reimbursement will be the lesser of the formula amount and the billed amount, less other insurance and spenddown, if any.</p> <p>*If ASA Relative Value units equal zero for the procedure/date of service, the anesthesia formula will not be used and the allowed amount will be computed by multiplying the billed amount by 45%.</p> <p>Note – the ANESTH pricing method is only used for dates of service after 06/30/2007 and is not used for every anesthesia procedure code. Please refer to additional anesthesia pricing criteria later in this section for further information.</p> <p>Note – Prior to the 5010 implementation (01/01/2012) providers billed in 15-minute increments so the units of service were not divided by 15 as they are currently (CO 16811).</p> <p><u>Procedure Code D9220</u></p> <p>Procedure code D9220 uses the MAXFEE Pricing method with rate type PSR (Physician Special Rate) rather than P4O or P4I - CO 9744.</p> <p><u>Procedure Code 99050</u></p> <p>For dates of service after 06/30/2007 procedure code 99050 uses the MAXFEE Pricing method with rate type PSR (Physician Special Rate) rather than P4O or P4I - CO 8319.</p> <p><u>Lab Services (80000 – 89999) (G0103, G0123, G0143 – G0145, G0147 – G0148, G0306, G0307, G0328, G0430 – G0431 added per CO 14349)</u></p> <p>Lab codes, other than pathology codes with dates of service 10/01/2002 or greater, use the MAXFEE pricing method and the PSO rate type.</p> <p><u>Pathology Codes</u></p> <p>Pathology codes for dates of service of 10/01/2002 or greater use the MAXFEE pricing method and the P4O rate type.</p> <p>If the DOS is Prior to and on 9/30/2002. Pathology codes will use the MAXFEE pricing method and the PSO rate type.</p> <p><u>Listing of Pathology Services</u></p> <table border="1"> <tr> <td>80500</td> <td>80502</td> <td>85060</td> <td>85095</td> <td>85097</td> <td>85102</td> <td>85390</td> <td>86077</td> </tr> <tr> <td>86078</td> <td>86079</td> <td>86485</td> <td>86490</td> <td>86510</td> <td>86580</td> <td>86585</td> <td>86586</td> </tr> <tr> <td>88104</td> <td>88106</td> <td>88107</td> <td>88108</td> <td>88112</td> <td>88120</td> <td>88121</td> <td>88125</td> </tr> </table>								80500	80502	85060	85095	85097	85102	85390	86077	86078	86079	86485	86490	86510	86580	86585	86586	88104	88106	88107	88108	88112	88120	88121	88125
80500	80502	85060	85095	85097	85102	85390	86077																								
86078	86079	86485	86490	86510	86580	86585	86586																								
88104	88106	88107	88108	88112	88120	88121	88125																								

88141	88160	88161	88162	88170	88171	88172	88173
88177	88180	88182	88291	88300	88302	88304	88305
88307	88309	88311	88312	88313	88314	88318	88319
88321	88323	88325	88329	88331	88332	88342	88346
88347	88348	88349	88355	88356	88358	88361	88362
88363	88365	88367	89100	89105	89130	89132	89135
89136	89140	89141	89350	89360			

Procedure codes 88120, 88121, 88177 and 88363 added to list of Pathology codes per CO 15370.

Procedure code 88367 added to list of Pathology codes effective with date of service 01/01/2011 per CO 15411.

Professional Component (modifier 26)

Services billed with a professional component will use the MAXFEE pricing method and will use the DEF rate type.

Technical Component (modifier TC)

Services billed with a technical component will use the MAXFEE pricing method and will use the DEF rate type.

Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service or if the applicable rate has an amount of zero, default pricing logic will be performed.

Dates of Service 08/01/2006 and After

If the date of service is 08/01/2006 or after and the procedure code is submitted without modifier 26 or TC, reimbursement is 45% of the billed amount.

Dates of Service prior to 08/01/2006

If the date of service is 08/01/2004 through 07/31/2006 and the procedure code is submitted without modifier 26 or TC, reimbursement is 65% of the billed amount.

Dates of Service prior to 08/01/2004

If the date of service is prior to 08/01/2004 and the procedure code is submitted without modifier 26 or TC, reimbursement is 45% of the billed amount.

Professional Component (modifier 26)

If there is no professional component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab and pathology service

	<p>codes.</p> <p style="text-align: center;"><u>Technical Component (modifier TC)</u></p> <p>If there is no technical component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab and pathology service codes.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>Assistance at Surgery</u></p> <p>Identified by modifier 80 or 82. These modifiers are set up as processing modifiers and percentage (16%) this information can be found on the Modifier panel.</p> <p><u>Bilateral Procedures</u></p> <p>Identified by modifier 50. This modifier is set up as processing modifiers and percentage</p> <p>150% - for DOS 8/1/2006 – 12/31/2299</p> <p>200% - for DOS prior to and on 7/31/2006</p> <p>This information can be found on the Modifier panel.</p> <p>With the exception of procedure codes 64470, 64472, 64475, 64476, 64479, 64480, 64483, and 64484 (per CO 9699), if the units of service is greater than 1, the bilateral percentage is not applied. Reimbursement rules exist for this situation.</p> <p>Also, if the service is procedure codes (00100 – 01999), the bilateral percentage is not applied. Reimbursement rules exist for this situation.</p> <p><u>Physician Assistant</u></p> <p>Identified by modifier U1 (DOS – 10/16/2003 – 12/31/2299)</p> <p>Identified by modifier PA (DOS – Prior to and on 10/15/2003)</p> <p>These modifiers (U1, PA) are set up as processing modifiers and percentage (75%).</p> <p>Note: Procedure codes beginning with ‘J’ pay 100% of the physician rate and are not reduce by the physician assistant factor. Procedure codes Q4101 and Q4106 pay 100% of the physician rate per CO 14936.</p> <p><u>Multiple Surgery</u></p> <p>The special pricing factor for claims with multiple surgical procedures performed on the same date of service is 100% for the highest service of all the possible multiple surgical services and 50% for every service considered a multiple surgery service on the same claim with the same date of service.</p>
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<p>If the units of service billed for the highest multiple surgical procedure is greater than one, one unit will price at 100% and the units exceeding one will price at 50% per CO 16402 (see note below).</p> <p>The list of services (i.e. procedure codes) for multiple surgery reduction are maintained by the following procedure groups:</p> <p>3073 (KY Medical Procedures 1 – effective 1/1/1900 – 12/31/2299)</p> <p>3074 (KY Medical Procedures 2 – effective 1/2/2004 – 12/31/2299)</p> <p>3075 (KY Medical Procedures 3 – effective 1/1/1900 - 1/1/2004)</p> <p>The list of services (i.e. procedure codes) excluded from the multiple surgery reduction are maintained by the following procedure groups:</p> <p>3013 (KY Medical Proc Exclusions 1 - effective 1/2/2004)</p> <p>3014 (KY Medical Proc Exclusions 2 - effective prior to and on 1/2/2004)</p> <p>This can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p>If a detail has a modifier of 26, it is excluded from the multiple surgery reduction.</p> <p>NOTE: MULTIPLE SURGERIES PRICING <u>BEFORE</u> CO 16402: If two surgeries are performed by the same physician on the same date of service and one is excluded, the multiple surgeries factor is not applied to either procedure. This also applies if more than two surgeries are performed and one or more is excluded. There has to be at least TWO or more non-excluded surgical codes for the multiple surgery reduction to be applied.</p> <p>NOTE: MULTIPLE SURGERIES PRICING PER CO 16402: Multiple surgeries pricing will apply when one non-excluded surgical procedure is billed with units of service greater than one or when two or more non-excluded surgical procedures are on the same claim with the same date of service.</p> <p>If the claim has a modifier of 80 or 82 (assistant surgery) involving multiple surgeries on the same date of service, the assistant surgery factor is applied before multiple surgery factor.</p> <p><u>Anesthesia (procedure codes 00100-01999)</u></p> <p>For dates of service after 06/30/2007 anesthesia procedures, with the exception of those listed below, are priced using the ANESTH pricing method and associated formula discussed previously in this section.</p> <p>The following anesthesia procedure codes pay using the MAXFEE pricing method described previously in this section: 01960, 01961, 01967, 01968, 01969. Note – these procedure codes are limited to 1 unit of service.</p> <p>The following anesthesia procedure codes pay 45% of the billed amount: 00539, 00548, 00561, 00580, 00604, 00754, 00756, 00796, .00836, 00868,</p>

	<p>00950, 01150, 01160, 01170, 01670, 01680, 01782, 01925, 01953, 01962, 01966, 01996, 01999.</p> <p>Anesthesia procedures for dates of service prior to 07/01/2007 are priced using the MAXFEE pricing method discussed previously in this section. Anesthesia procedures for dates of service prior to 07/01/2007 are limited to 1 unit of service.</p>
Evaluation and management procedure codes	<p>Evaluation and management procedure codes 99214, 99215, 99349, and 99350 are priced using the MAXFEE pricing method using either the P4I or the P4O rate type based on the place of service. However, these services are subject to annual maximums and if those maximums are exceeded these procedure codes pay a reduced rate. Please refer to Audits 5101, 5102, 6210, and 6753 in the Audit Manual for further information.</p>
“Brown Bagging” J-codes/NDCs	<p>For dates of service 07/01/2007 and after Brown Bagging drugs are submitted with a National Drug Code (NDC) and are priced using the following formula:</p> $[(\text{AWP Rate minus } 10\%) \times \text{Drug Quantity}]$ <p>Since multiple drugs can be billed for a particular claim detail, this formula is applied to every NDC on that claim detail. Their products are then added together and compared to the detail billed amount. Medicaid reimbursement is the lesser of the two.</p> <p>Brown bagging drugs have NDC codes and J-codes that are listed in the “NDC Group Type” table (J-code/NDC Cross-Reference) and can be viewed by selecting Related Data/Other, then NDC Group Type under the Reference Subsystem. AWP rates for a particular NDC are listed in the “AWUP” field and can be viewed on the Reference Drug panel by selecting “AWP Rates.” Rates are determined based on the detail from date of service.</p> <p>Note – If J-code J3590 is submitted with NDC 50242006001 or 50242006101, reimbursement is the lesser of the billed amount or the procedure code rate (units of service are <u>not</u> considered). Rate type P4I is used for details with a place of service code of 21, 24, 51, 61, or 62. Rate type P4O is used for details billed with a place of service code other than 21, 24, 51, 61, or 62.</p>

4.9.11 Claim Type M: Chiropractic (Prov Type 85)

Alpha Claim Type	M (formerly Legacy J)	Provider Type	85
DOS Effective		Adjudication Date Effective	
Provider Contract	CHIRO	Reimbursement Classification	RC Professional Svcs
Methodology/Logic	<p>Chiropractic claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>MAXFLT (Max Flat Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code and/or modifier combination) from the Max Fee panel, for the rate type (P4O), (P4I), (PSO), (DEF) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay amount and other insurance and spenddown, if any).</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (P4O), (P4I) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance and spenddown, if any).</p> <p><u>Lab Services (80000 – 89999)</u></p> <p>Lab codes will use the MAXFEE pricing method and the PSO rate type.</p> <p><u>Professional Component (modifier 26)</u></p> <p>Services billed with a professional component will use the MAXFEE pricing method and will use the DEF rate type.</p> <p><u>Technical Component (modifier TC)</u></p> <p>Services billed with a technical component will use the MAXFEE pricing method and will use the DEF rate type.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be preformed.</p> <p><u>Non Lab Services</u></p> <p><u>If the place of service (POS) is 21, 24, 51, 61 or 62</u></p>		

	<p>AND the date of service (DOS) is 1/1/1900 – 12/31/2299, the reimbursement is 50% of the billed amount.</p> <p><u>If the place of service (POS) is other than 21, 24, 51, 61 or 62</u></p> <p>AND the date of service (DOS) is 1/1/1900 – 12/31/2299, the reimbursement is 65% of the billed amount.</p> <p><u>Lab Services</u></p> <p>If the service (i.e. procedure code) is a lab procedure code (80001 – 89399), the reimbursement is 65% of the billed amount. The lab services are maintained by a procedure group (3072 – ALL LABS) which can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p><u>Professional Component (modifier 26)</u></p> <p>If there is no professional component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab service codes.</p> <p><u>Technical Component (modifier TC)</u></p> <p>If there is no technical component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab service codes.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>Assistance at Surgery</u></p> <p>Identified by modifier 80 or 82. These modifiers is set up as processing modifiers and percentage (16%) this information can be found on the Modifier panel.</p> <p><u>Bilateral Procedures</u></p> <p>Identified by modifier 50. This modifier is set up as processing modifiers and percentage</p> <p>150% - for DOS 8/1/2006 – 12/31/2299</p> <p>200% - for DOS prior to and on 7/31/2006</p> <p>this information can be found on the Modifier panel.</p> <p>If the units of service is greater than 1, the bilateral percentage is not applied. Reimbursements rules exists for this situation.</p> <p>Also, if the service is procedure codes (00100 – 01999), the bilateral percentage is not applied. Reimbursements rules exists for this situation.</p> <p><u>Multiple Surgery</u></p>
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	<p>The special pricing factor for claims with multiple surgical procedures performed on the same date of service is 100% for the highest service of all the possible multiple surgical services and 50% for every service considered a multiple surgery service on the same claim with the same date of service.</p> <p>The list of services (i.e. procedure codes) for multiple surgery reduction are maintained by the following procedure groups:</p> <p>3073 (KY Medical Procedures 1 – effective 1/1/1900 – 12/31/2299)</p> <p>3074 (KY Medical Procedures 2 – effective 1/2/2004 – 12/31/2299)</p> <p>3075 (KY Medical Procedures 3 – effective 1/1/1900 - 1/1/2004)</p> <p>The list of services (i.e. procedure codes) excluded from the multiple surgery reduction are maintained by the following procedure groups:</p> <p>3013 (KY Medical Proc Exclusions 1 - effective 1/2/2004)</p> <p>3014 (KY Medical Proc Exclusions 2 - effective prior to and on 1/2/2004)</p> <p>this can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p>If a detail has a modifier of 26, it is excluded from the multiple surgery reduction.</p> <p>If two surgeries are performed by the same physician on the same date of service and one is excluded, the multiple surgery factor is applied to either procedure. This also applies if more than two surgeries are performed and one or more is excluded.</p> <p>If the claim has a modifier of 80 or 82 (assistant surgery) involving multiple surgeries on the same date of service, the assistant surgery factor is applied before multiple surgery factor.</p>
Exceptions	There are no exceptions.

4.9.12 Claim Type M: Early Periodic Screening, Diagnosis, And Testing (EPSDT-Prov Type 40)

Alpha Claim Type	M (formerly Legacy K)	Provider Type	40
Provider Contract	EPSDT	Reimbursement Classification	RC EPSDT
Methodology/Logic	EPSDT claims will price using the pricing method: MAXFEE (Max Fee)		

	<p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (P4O), (EP1) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>Pricing Method (10/16/2003 – 12/31/2299):</p> <p>The MAXFEE pricing method is used for all services with the rate type (P4O).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p>Pricing Method (Prior to and on 10/16/2003):</p> <p>The MAXFEE pricing method is used for all services with the rate type (EP1).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.13 Claim Type M: EPSDT–Related Services (Prov Type 45)

Alpha Claim Type	M (formerly Legacy K)	Provider Type	45
Provider Contract	EPSPS	Reimbursement Classification	Standard
Methodology/Logic	<p>EPSDT–Related Services will price using the pricing method: LPABIL (Lesser of PA or Bill Amt)</p> <p>Pricing Method(s):</p> <p>Services will have a “Y” PA indicator on the provider contract for the provider (EPSDT-Related Services). The LPABIL pricing method will be used. This compares the PA amount versus the Max Fee for the service (i.e. procedure code). The reimbursement is determined by comparing the detail billed amount to the prior authorized amount listed on the Prior Authorization file. The reimbursement is the lesser of the two (less other</p>		

	insurance and spenddown, if any). Default Pricing Logic: None Pricing Method - Services which price from PA: None Additional Reimbursement Info: None
Exceptions	There are no exceptions.

4.9.14 Claim Type M: Ambulatory Surgical Center (ASC) (Prov Type 36)

Alpha Claim Type	M (formerly Legacy M)	Provider Type	36
Provider Contract	ASC	Reimbursement Classification	Standard
Methodology/Logic	ASC claims will price using the pricing method: ASC (Ambulatory Surgical Cntr) MAXFEE (Max Fee) PPRPCT (Provider Priced Percnt) MANUAL (Manual) Pricing Method(s): The ASC pricing method will obtain the rte for the service (i.e. procedure code) from the ASC Pricing panel, for the rate type (DEF) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any). For ASC pricing, you'll use the ASC Payment Group panel to determine which ASC payment group the service (procedure code) is in. The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (PSI) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any). The PPRPCT pricing method will get the provider's specific percentage rate using the (ASD) rate type for the date of service on the claim (detail). The provider's specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).		

	<p>The MANUAL pricing method will be manual priced by the user.</p> <p><u>Lab Services (80000 – 89999, 34615 procedure codes) (G0433 – G0435, G9143 and Q0115 procedure codes added per CO 15266)</u></p> <p>Lab codes will use the MAXFEE pricing method and the PSI rate type.</p> <p><u>If the service is a dental D0120 – D9999 (procedure code)</u></p> <p>The PPRPCT will be used for these services.</p> <p><u>Services with a modifier of 59 - (DISTINCT PROCEDURAL SERVICE)</u></p> <p>These services will be manually priced.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be preformed.</p> <p>If the DOS is 10/1/2002 – 12/31/2299, the reimbursement is 45% of the billed amount.</p> <p>If the DOS is prior to or on 9/30/2002, the reimbursement is 65% of the billed amount.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>Bilateral Procedures</u></p> <p>Identified by modifier 50. This modifier is set up as processing modifiers and percentage</p> <p>150% - for DOS 8/1/2006 – 12/31/2299</p> <p>200% - for DOS prior to and on 7/31/2006</p> <p>this information can be found on the Modifier panel.</p> <p>If the units of service are greater than 1, the bilateral percentage is not applied. Reimbursements rules exist for this situation.</p> <p>Also, if the service is procedure codes (00100 – 01999), the bilateral percentage is not applied. Reimbursements rules exist for this situation.</p> <p><u>Multiple Surgery</u></p> <p>The special pricing factor for claims with multiple surgical procedures performed on the same date of service is 100% for the highest service of all the possible multiple surgical services and 50% for every service considered a multiple surgery service on the same claim with the same date of service.</p> <p>The list of services (i.e. procedure codes) for multiple surgery reduction are maintained by the following procedure groups:</p> <p>3073 (KY Medical Procedures 1 – effective 1/1/1900 – 12/31/2299)</p>
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	<p>3074 (KY Medical Procedures 2 – effective 1/2/2004 – 12/31/2299)</p> <p>3075 (KY Medical Procedures 3 – effective 1/1/1900 - 1/1/2004)</p> <p>The list of services (i.e. procedure codes) excluded from the multiple surgery reduction are maintained by the following procedure groups:</p> <p>3013 (KY Medical Proc Exclusions 1 - effective 1/2/2004)</p> <p>3014 (KY Medical Proc Exclusions 2 - effective prior to and on 1/2/2004)</p> <p>this can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p>If a detail has a modifier of 26, it is excluded from the multiple surgery reduction.</p> <p>If two surgeries are performed by the same physician on the same date of service and one is excluded, the multiple surgery factor is applied to either procedure. This also applies if more than two surgeries are performed and one or more is excluded.</p> <p>If the claim has a modifier of 80 or 82 (assistant surgery) involving multiple surgeries on the same date of service, the assistant surgery factor is applied before multiple surgery factor.</p>
Exceptions	There are no exceptions.

4.9.15 Claim Type M: Transportation/Ambulance (Prov Type 55)

Alpha Claim Type	M (formerly Legacy N)	Provider Type	55
Provider Contract	TRNSP	Reimbursement Classification	Standard
Methodology/Logic	<p>Transportation claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>MAXFLT (Max Flat)</p> <p>ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (MX1), (MX2), (TR1), (TR2), (TR3), (TR4) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance, if</p>		

	<p>any).</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (MX1), (TR5), (TR6), (TR7) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance , if any).</p> <p>The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>Pricing Method (10/16/2003 – 12/31/2299):</p> <p>The MAXFEE pricing method is used for all services (procedure codes) except for A0427, A0429, A0430, A0431, A0435, A0436, A0420, A0424.</p> <p>The MAXFLT pricing method is used for services (procedure codes) A0427, A0429, A0430, A0431.</p> <p>The ZEROPD pricing method is used for services (procedure codes) A0435, A0436, A0420, A0424.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p>Pricing Method (6/1/2003 – 10/15/2003):</p> <p>The MAXFEE pricing method is used for services (procedure codes) A0030, A0010, A0020, A0070, A0215, A0222, A0368, A0382, A0398.</p> <p>The MAXFLT pricing method is used for services (procedure codes) A0340, A0342, A0348, A0426, A0427, A0428, A0430, A0431, A0433, A0434, A0429. Reimbursement rules exist to support the various modifiers (overridden to pricing) and Benefit Adjustment Factor (BAF) for the various services, and units.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p>Pricing Method (Prior to and on 5/31/2003):</p> <p>The MAXFEE pricing method is used for services (procedure codes) A0030, A0010, A0020, A0070, A0215, A0222, A0368, A0382, A0398.</p>
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	<p>The MAXFLT pricing method is used for services (procedure codes) A0362, A0030, A0330, A0340, A0342, A0348, A0360, A0340, A0342, A0348, A0426, A0427, A0428, A0430, A0431, A0433, A0434, A0429. Reimbursement rules exist to support the various modifiers (overridden to pricing) and Benefit Adjustment Factor (BAF) for the various services, and units.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.16 Claim Type M: Non-emergency transportation (prov type 56, specialty 16)

Alpha Claim Type	M (formerly Legacy N)	Provider Type	56
Provider Contract	NET NETRP	Reimbursement Classification	RC Non-Emerg Trans
Methodology/Logic	<p>Non-emergency Transportation claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>MAXFLT (Max Flat)</p> <p>BILLED (Billed)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (MX1), (N1A), (N1B), (N2F), (N7B), (N8B) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance, if any).</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (N2A), (N7A), (N8A), (N2B), (N2C), (N2D), (N2E), (N2G), (NT2) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance , if any).</p> <p>The BILLED pricing method will be reimbursed the billed amount on the detail (less other insurance , if any).</p>		

	<p>Pricing Method (7/1/2003 – 12/31/2299):</p> <p>The MAXFEE pricing method is used for all services. For service T2005 (procedure code) reimbursement rules exist to include/exclude the GM (MULTIPLE TRANSPORTS) modifier and to override the modifier to pricing.</p> <p>Pricing Method (5/1/2003 – 6/30/2003):</p> <p>The Billed pricing method was used during this time period for all services.</p> <p>Pricing Method (Prior to and on 4/30/2003):</p> <p>Either the MAXFEE or the MAXFLT pricing method will be performed based on the specific service, the provider specialty and the member’s county (residence). For service A0150 (procedure code), a Benefit Adjustment Factor (BAF) exists in conjunction with rate type N8A and N8B.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.17 Claim Type M: Audiology (Prov Type 50/70)

Alpha Claim Type	M (formerly Legacy P)	Provider Type	50/70
Provider Contract	HEAR (PT 50) AUDIO (PT 70)	Reimbursement Classification	RC Audiology
Methodology/Logic	<p>Audiology claims will price using the pricing methods:</p> <p>BILLED (Billed Amount)</p> <p>MAXFEE (Max Fee)</p> <p>Pricing Method(s):</p> <p>For hearing aid related procedure codes V5030, V5040, V5050, V5060, V5070, V5080, V5100, V5120, V5130, V5140, V5150, V5170, V5180, V5190, V5210, V5220, V5230, and V5242 thru V5263 with dates of service of 11/20/2007 or after, the BILLED pricing method is used. These procedure codes pay 100% of the billed amount. However, please note that payments for these codes are subject to comparison and limitation to the invoice amount and limitations monitored by Audits 6737 and 6738.</p> <p>For services other than those listed above the MAXFEE pricing method is</p>		

	<p>used. It obtains the rate for the service/procedure code from the Max Fee panel for the date of service using rate type P5O. The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>Default Pricing Logic: If a rate is not found for the procedure code for the date of service, default pricing logic will be performed. The reimbursement is 65% of the billed amount.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.18 Claim Type M: Optician (Prov Type 52)

Alpha Claim Type	M (formerly Legacy P)	Provider Type	52
Provider Contract	OPTI	Reimbursement Classification	RC Optician
Methodology/Logic	<p>Optician claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>MAXFLT (Max Flat Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code and/or modifier combination) from the Max Fee panel, for the rate type (P4O), (P4I), (P6O), (PSO) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (OT1) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less copay, other insurance and spenddown, if any).</p> <p><u>Services 92340, 92341, 92352, 92353, 92370 (procedure code)</u></p> <p>If the place of service is 21, 24, 51, 61, or 62, the P4I rate type will be used with the MAXFEE pricing method.</p>		

	<p>If the place of service is other than 21, 24, 51, 61, or 62, the P4O rate type will be used with the MAXFEE pricing method.</p> <p><u>Lab Services (80000 – 89999)</u></p> <p>Lab codes will use the MAXFEE pricing method and the PSO rate type.</p> <p><u>All other services (procedure code)</u></p> <p>All other services will use the MAXFEE pricing method and the P6O rate type.</p> <p><u>Service 92499 (procedure code)</u></p> <p>This service will use the MAXFLT pricing method and the OT1 rate type.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be preformed.</p> <p>If the place of service (POS) is 21 or 51, the reimbursement is 50% of the billed amount.</p> <p>If the place of service (POS) is other than 21 or 51, the reimbursement is 65% of the billed amount.</p> <p><u>Lab Services</u></p> <p>If the service (i.e. procedure code) is a lab procedure code (80001 – 89399), the reimbursement is 65% of the billed amount. The lab services are maintained by a procedure group (3072 – ALL LABS) which can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.19 Claim Type M: Optometrist (Prov Type 77)

Alpha Claim Type	M (formerly Legacy P)	Provider Type	77
Provider Contract	OPTP	Reimbursement Classification	RC Optpmetrist
Methodology/Logic	<p>Optometrist claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>MAXFLT (Max Flat Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e.</p>		

	<p>procedure code and/or modifier combination) from the Max Fee panel, for the rate type (P4O), (P4I), (P6O), (PSO) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type (OT1), (P4O), (P4I) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less copay, other insurance and spenddown, if any).</p> <p><u>Lab Services (80000 – 89999)</u></p> <p>Lab codes will use the MAXFEE pricing method and the PSO rate type.</p> <p><u>Service 92499 (procedure code)</u></p> <p>The MAXFLT pricing method is used for this service with a rate type of OT1.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be preformed.</p> <p><u>Non Lab Services</u></p> <p><u>If the place of service (POS) is 21 or 51</u></p> <p>The reimbursement is 50% of the billed amount.</p> <p><u>Non Lab Services</u></p> <p><u>If the place of service (POS) is other than 21 or 51</u></p> <p>The reimbursement is 65% of the billed amount.</p> <p><u>Lab Services (80000 – 89999)</u></p> <p>If the service (i.e. procedure code) is a lab procedure code (80001 – 89399), the reimbursement is 65% of the billed amount. The lab services are maintained by a procedure group (3072 – ALL LABS) which can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p><u>Professional Component (modifier 26)</u></p> <p>If there is no professional component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab service codes.</p> <p><u>Technical Component (modifier TC)</u></p> <p>If there is no technical component rate for the procedure code, the (P4O)</p>
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	<p>rate type will be used if available. This applies for lab service codes.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>Assistance at Surgery</u></p> <p>Identified by modifier 80 or 82. These modifiers is set up as processing modifiers and percentage (16%) this information can be found on the Modifier panel.</p> <p><u>Bilateral Procedures</u></p> <p>Identified by modifier 50. This modifier is set up as processing modifiers and percentage</p> <p>150% - for DOS 8/1/2006 – 12/31/2299</p> <p>200% - for DOS prior to and on 7/31/2006</p> <p>this information can be found on the Modifier panel.</p> <p>If the units of service is greater than 1, the bilateral percentage is not applied. Reimbursements rules exists for this situation.</p> <p>Also, if the service is procedure codes (00100 – 01999), the bilateral percentage is not applied. Reimbursements rules exists for this situation.</p> <p><u>Physician Assistant</u></p> <p>Identified by modifier U1 (DOS – 10/16/2003 – 12/31/2299)</p> <p>Identified by modifier PA (DOS – Prior to and on 10/15/2003)</p> <p>These modifiers (U1, PA) are set up as processing modifiers and percentage (75%).</p> <p><u>Multiple Surgery</u></p> <p>The special pricing factor for claims with multiple surgical procedures performed on the same date of service is 100% for the highest service of all the possible multiple surgical services and 50% for every service considered a multiple surgery service on the same claim with the same date of service.</p> <p>The list of services (i.e. procedure codes) for multiple surgery reduction are maintained by the following procedure groups:</p> <p>3073 (KY Medical Procedures 1 – effective 1/1/1900 – 12/31/2299)</p> <p>3074 (KY Medical Procedures 2 – effective 1/2/2004 – 12/31/2299)</p> <p>3075 (KY Medical Procedures 3 – effective 1/1/1900 - 1/1/2004)</p>
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The list of services (i.e. procedure codes) **excluded** from the multiple surgery reduction are maintained by the following procedure groups:

3013 (KY Medical Proc Exclusions 1 - effective 1/2/2004)

3014 (KY Medical Proc Exclusions 2 - effective prior to and on 1/2/2004)

this can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).

If a detail has a modifier of 26, it is **excluded** from the multiple surgery reduction.

If two surgeries are performed by the same physician on the same date of service and one is excluded, the multiple surgery factor is applied to either procedure. This also applies if more than two surgeries are performed and one or more is excluded.

If the claim has a modifier of 80 or 82 (assistant surgery) involving multiple surgeries on the same date of service, the assistant surgery factor is applied before multiple surgery factor.

Selected Procedures (Optometrist)

List of services that will use the P4I or P4O rate type based on the place of service on the claim with the MAXFEE & MAXFLT pricing methods. It is best to view the reimbursement rule(s) for a given service as services may be added and/or deleted without this listing being updated.

10060	76511	92284	97530	99261
10061	76512	92285	97770	99262
11000	76513	92286	99050	99263
11050	76516	92287	99178	99271
11440	76519	92310	99201	99272
15851	76529	92311	99202	99273
17000	76999	92312	99203	99274
17001	90901	92313	99204	99275
17002	92002	92340	99205	99281
17010	92004	92341	99211	99282
17110	92012	92352	99212	99283
65205	92014	92353	99213	99284
65210	92015	92370	99214	99285
65220	92018	92531	99215	99301
65222	92019	92532	99217	99302
65286	92020	92533	99218	99303
65430	92060	92534	99219	99311

	65435	92065	92541	99220	99312
	65436	92070	92542	99221	99313
	65600	92081	92543	99222	99321
	67700	92082	92544	99223	99322
	67710	92083	92545	99231	99323
	67820	92100	92546	99232	99331
	67825	92120	92547	99233	99332
	67840	92130	94010	99238	99333
	67850	92140	94150	99239	99341
	67938	92225	95060	99241	99342
	68020	92226	95930	99242	99343
	68040	92230	95999	99243	99351
	68135	92235	96111	99244	99352
	68530	92250	96115	99245	99353
	68760	92260	96117	99251	
	68761	92265	97110	99252	
	68801	92270	97112	99253	
	68810	92275	97139	99254	
	68840	92283	97150	99255	
Exceptions	There are no exceptions.				

4.9.20 Claim Type M: Primary Care (Prov Type 31)

Alpha Claim Type	M (formerly Legacy Q)	Provider Type	31
Provider Contract	PCARE	Reimbursement Classification	RC PriCare/RuralHlth
Methodology/Logic	<p>Primary Care claims will price using the pricing method: PCRURL (Per Diem Rate Reimburse) ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The PCRURL pricing method will pay the per diem rate once for the entire claim if one or more details on a claim have a rendering provider type of 60, 61, 64, 65, 77, 78, 80, 82, 89, or 95 and a ‘pay’ procedure code (listed</p>		

	<p>below).</p> <p>The provider's specific rate can be found on the Provider Rate panel for that provider using the (PCC) rate type. The reimbursement is the per diem rate (less copay, other insurance and spenddown, if any).</p> <p>In order to just pay the per diem once per claim, the reimbursement rule(s) will be set with the bundle pricing flag set to F (First bundled service only). Once a per diem rate has been applied, all the other details will price at zero dollars (\$0). If no per diem rate is found, the entire claim pays zero. Also, once a per diem has been paid for a specific date of service, no additional payment will be made for that date of service if submitted on a separate claim (see Audit 5017).</p> <p>The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p> <p style="text-align: center;">TABLE OF 'PAY' PROCEDURE CODES (effective 04/27/2004)</p> <p>D0110 – D9420</p> <p>S0610</p> <p>S0612</p> <p>V2020</p> <p>V2100 - V2499</p> <p>V5000 - V5220</p> <p>W0030</p> <p>W0073 - W0075</p> <p>W0080</p> <p>W0090</p> <p>W0091 - W0094</p> <p>W0716 - W0726</p> <p>W2025</p> <p>W3051</p> <p>W3052</p>
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WP101
WP102
WP111 - WP113
X1100 - X1190
X1200 - X1290
X1300 - X1359
X1361 - X1390
X1500 - X1590
Y0002
Y0003
Y6000
Z9084
00140 - 09420
10000 - 35999
36681 - 69999
90000 - 90475
90478 - 90580
90582 - 90584
90587 - 90631
90635 – 90635
90637 – 90644
90649 – 90656
90661 – 90664
90666 – 90668
90670 – 90674
90677 – 90679
90681 – 90689
90694 – 90699
90750 – 90781

90800 – 92999

93001 - 94199

94201 - 94639

94641 - 94663

94666 - 95114

95200 – 99198

99200 – 99400

99405 – 99428

99430 – 99999

TABLE OF ‘PAY’ PROCEDURE CODES
(effective 12/19/02 thru 04/26/2004)

D0110 – D9420

S0610

S0612

V2020

V2100 - V2499

V5000 - V5220

W0030

W0073 - W0075

W0080

W0090

W0091 - W0094

W0716 - W0726

W2025

W3051

W3052

WP101

WP102

WP111 - WP113

X1100 - X1190

X1200 - X1290
X1300 - X1359
X1361 - X1390
X1500 - X1590
Y0002
Y0003
Y6000
Z9084
00140 - 09420
10000 - 35999
36681 - 69999
90000 - 90475
90478 - 90580
90582 - 90584
90587 - 90631
90635 – 90635
90637 – 90644
90649 – 90656
90661 – 90664
90666 – 90668
90670 – 90674
90677 – 90679
90681 – 90689
90694 – 90699
90750 – 90781
90800 – 92999
93001 - 94199
94201 - 94639
94641 - 94663

	94666 - 95114 95200 – 99198 99200 – 99400 99405 - 99999
Exceptions	Claims submitted by providers listed in the T_EDIT_PARMS table (if any) are reimbursed using the logic/rules set up for the rendering provider type submitted on each detail (CO 16017). In these cases multiple details on the same claim can pay. Please refer to the sections in this manual referencing pricing for those provider types. Please note that rendering provider type 95 pricing uses the Physician/modifier U1 (physician assistant) methodology. Please also note that details with a rendering provider type of 31 will pay zero.

4.9.21 Claim Type M: Rural Health (Prov Type 35)

Alpha Claim Type	M (formerly Legacy Q)	Provider Type	35
Provider Contract	RHC RHCLC	Reimbursement Classification	RC PriCare/RuralHlth
Methodology/Logic	<p>Rural Health claims will price using the pricing method:</p> <p>PCRURL (Per Diem Rate Reimburse)</p> <p>PPRPCT (Provider Priced Percent)</p> <p>ZEROPD (Zero Paid)</p> <p>Pricing Method(s):</p> <p>The PCRURL pricing method will pay the per diem rate once for the entire claim if one or more details on a claim have a rendering provider type of 60, 61, 64, 65, 77, 78, 80, 82, 89, or 95 and one of the ‘pay’ procedure codes listed below.</p> <p>The provider’s specific rate can be found on the Provider Rate panel for that provider using the (RH1) rate type. The reimbursement is the per diem rate (less copay, other insurance and spenddown, if any).</p> <p>In order to just pay the one per diem, the reimbursement rule(s) will be set with the bundle pricing flag set to F (First bundled service only). Once a per diem rate has been applied, all the other details will price at zero dollars (\$0). Also, once a per diem has been paid for a specific date of service, no additional payment will be made for that date of service if submitted on a separate claim (see Audit 5017).</p> <p>If no per diem rate is found, the entire claim pays zero. The PPRPCT pricing method will get the provider’s specific percentage rate using the</p>		

(RH2) rate type for the date of service on the claim (detail). The provider's specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, other insurance and spenddown, if any).

The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.

Default Pricing Logic: None

Pricing Method - Services which price from PA: None

Additional Reimbursement Info: None

**TABLE OF 'PAY' PROCEDURE CODES
(effective 04/27/2004)**

D0110 – D9420

S0610

S0612

V2020

V2100 - V2499

V5000 - V5220

W0030

W0073 - W0075

W0080

W0090

W0091 - W0094

W0716 - W0726

W2025

W3051

W3052

WP101

WP102

WP111 - WP113

X1100 - X1190

X1200 - X1290
X1300 - X1359
X1361 - X1390
X1500 - X1590
Y0002
Y0003
Y6000
Z9084
00140 - 09420
10000 - 35999
36681 - 69999
90000 - 90475
90478 - 90580
90582 - 90584
90587 - 90631
90635 – 90635
90637 – 90644
90649 – 90656
90661 – 90664
90666 – 90668
90670 – 90674
90677 – 90679
90681 – 90689
90694 – 90699
90750 – 90781
90800 – 92999
93001 - 94199
94201 - 94639
94641 - 94663

94666 - 95114

95200 – 99198

99200 – 99400

99405 – 99428

99430 – 99999

TABLE OF ‘PAY’ PROCEDURE CODES
(effective 12/19/02 thru 04/26/2004)

D0110 – D9420

S0610

S0612

V2020

V2100 - V2499

V5000 - V5220

W0030

W0073 - W0075

W0080

W0090

W0091 - W0094

W0716 - W0726

W2025

W3051

W3052

WP101

WP102

WP111 - WP113

X1100 - X1190

X1200 - X1290

X1300 - X1359

X1361 - X1390

X1500 - X1590

Y0002
Y0003
Y6000
Z9084
00140 - 09420
10000 - 35999
36681 - 69999
90000 - 90475
90478 - 90580
90582 - 90584
90587 - 90631
90635 – 90635
90637 – 90644
90649 – 90656
90661 – 90664
90666 – 90668
90670 – 90674
90677 – 90679
90681 – 90689
90694 – 90699
90750 – 90781
90800 – 92999
93001 - 94199
94201 - 94639
94641 - 94663
94666 - 95114
95200 – 99198
99200 – 99400
99405 - 99999

Exceptions	Claims submitted by providers listed in the T_EDIT_PARMS table (if any) are reimbursed using the logic/rules set up for the rendering provider type submitted on each detail (CO 16017). In these cases multiple details on the same claim can pay. Please refer to the sections in this manual referencing pricing for those provider types. Please note that rendering provider type 95 pricing uses the Physician/modifier U1 (physician assistant) methodology. Please also note that details with a rendering provider type of 35 will pay zero.
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4.9.22 Claim Type M: Adult Day Care Center (Prov Type 43)

DMS Approved 06/22/2009

Alpha Claim Type	M (formerly Legacy U)	Provider Type	43
Provider Contract	ADC ADCCD	Reimbursement Classification	RC Adult Day Care
Methodology/Logic	<p>Adult Day Care claims will price using the pricing methods:</p> <p>UCBILL (UCC Billing Provider)</p> <p>MAXFEE (Max Fee)</p> <p>BILLED (Pay as Billed)</p> <p>Pricing Method(s):</p> <p>For claims <u>other than</u> Consumer Directed Option and MFP, the UCBILL pricing method is used for all ADC procedure codes with the exception of T1005 and E1399 (note - UCBILL <u>is</u> used for T1005 for ABI LTC member claims but not for other claims). The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for the date of service using rate type AD3 for ABI LTC Waiver member claims, AD2 for Michelle P Waiver member claims and AD1 for all others. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and patient liability, if any).</p> <p>Procedure codes T1005 (with the exception of ABI LTC Waiver member claims) and E1399 pay 100% of the billed amount (less other insurance and patient liability, if any). Note – for ABI LTC Waiver member claims E1399 pays 100% of the billed up to the approved amount on the prior authorization. The BILLED pricing method is used to reimburse a detail at 100% of the detail billed amount on the claim.</p> <p><u>Consumer Directed Option (CDO) Claims</u></p> <p>For dates of service prior to 07/01/2008 CDO claims paid 100% of the billed amount (less other insurance, if any). Patient liability is not</p>		

	<p>deducted from CDO claims with dates of service prior to 07/01/2008.</p> <p>For dates of service after 06/30/2008 CDO claims (other than for MFP members) are priced as follows:</p> <p>Procedure code T2040 uses the MAXFEE pricing method. The MAXFEE pricing method obtains the rate for the procedure code from the Max Fee panel using rate type MX1 for the claim date of service. The rate is multiplied by the units of service on the detail and this value is compared to the billed amount. Reimbursement is the lesser of the two (less other insurance, if any).</p> <p>Procedure code T2022 uses the UCBILL pricing method. The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for rate type AD3 for ABI LTC members and AD2 for all other members for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance <u>and patient liability</u>, if any).</p> <p>CDO claims for procedure code T1028 must be submitted with an SC modifier. T1028SC uses the UCBILL pricing method. The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for rate type AD2 (for all members – not just Michelle P) for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance, if any).</p> <p>All other procedure codes pay 100% of the detail billed amount (less other insurance, if any). Note – Procedure codes T2019, S5108, and T1999 allow 100% of the billed amount until the dollar limit on the prior authorization (PA) is reached (monitored by PA Edit 3006). Only the authorized dollar amount will be placed on PAs for these procedure codes. Units of service will not be placed on the PA and will not be considered in the pricing. Once the prior authorized dollar amount is reached for these codes, no additional payment will be made. For example, if the PA for one of the codes has a remaining balance of \$50.00 and the provider bills \$75.00, the allowed amount will be cut back to the remaining \$50.00. If a claim is submitted and the remaining balance is zero, the claim will be denied.</p> <p><u>Money Follows the Person (MFP) Claims</u></p> <p>For claims submitted for members with an MFP assignment plan (including CDO) the MAXFEE pricing method is used for all applicable ADC procedure codes with the exception of E1399, S5108, T2019 and E1999. The MAXFEE pricing method obtains the rate for the procedure code from the Procedure Max Fee panel for rate type “MFP” for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance <u>and patient liability</u>, if any).</p> <p>Procedure codes E1399, S5108, T2019, and T1999 allow 100% of the</p>
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	<p>billed amount until the dollar limit on the prior authorization is reached (monitored by PA Edit 3006). Only the authorized dollar amount will be placed on PAs for these procedure codes. Units of service will not be placed on the PA and will not be considered in the pricing. Once the prior authorized dollar amount is reached for these codes, no additional payment will be made.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA:</p> <p>T2019, S5108, T1999, E1399</p> <p>Additional Reimbursement Info:</p> <p>NOTE: Payment of procedure code T1005 is subject to reimbursement limitation audit.</p>
Exceptions	There are no exceptions.

4.9.23 **Claim Type M: Supports For Community Living (Prov Type 33)**

DMS Approved 10/06/2009

Alpha Claim Type	M (formerly Legacy U)	Provider Type	33
Provider Contract	SCLWV SCLCD	Reimbursement Classification	RC SCL Waiver
Methodology/Logic	<p>Support for Community Living claims will price using the pricing methods:</p> <p>UCBILL (UCC Billing Provider)</p> <p>ZEROPD (Zero Paid)</p> <p>BILLED (Pay as Billed)</p> <p>MAXFEE (Max Fee)</p> <p>Pricing Method(s) :</p> <p>For claims <u>other than</u> Consumer Directed Option (CDO) and MFP, the UCBILL pricing method is used for all SCL procedure codes with the exception of T1005 and E1399 (note - UCBILL <u>is</u> used for T1005 for ABI LTC member claims but not for other claims). The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel using rate type SC1, SC2, SC3, SC5 or SC6 for the claim date or service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and patient liability, if any).</p> <p>The reimbursement rule(s) are set up with a High Intensity parameter value. The High Intensity value is obtained from the Member SNAP Data panel</p>		

<p>(Member subsystem). If the member's High Intensity indicator is a 'Y', rate type SC2 is used. If the member's High Intensity indicator is a 'D', rate type SC3 is used. Note - For dates of service 06/01/2006 and after, only procedure codes T2033 and E1399 are payable for members with a High Intensity Indicator of 'D'. All other procedure codes pay zero. For dates of service prior to 06/01/2006 only T2033 is payable. The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>A rate type of SC5 is used for members with a Michelle P Waiver assignment plan.</p> <p>A rate type of SC6 is used for members with an ABI-LTC Waiver assignment plan.</p> <p>For all other cases rate type SC1 is used.</p> <p>Procedure code T1005 (with the exception of ABI LTC Waiver member claims) pays 100% of the billed amount (less other insurance and patient liability, if any).</p> <p>Procedure code E1399 for ABI LTC Waiver member claims pays 100% of the billed up to the approved amount on the prior authorization. For all other members E1399 pays 100% of the billed up to the approved amount on the prior authorization for dates of service 05/01/2009 and after. For dates of service prior to 05/01/2009 E1399 is manually priced.</p> <p>The BILLED pricing method is used to reimburse a detail at 100% of the detail billed amount on the claim.</p> <p><u>Consumer Directed Option (CDO) Claims</u></p> <p>For dates of service prior to 07/01/2008 CDO claims paid 100% of the billed amount (less other insurance, if any). Patient liability is not deducted from CDO claims.</p> <p>For dates of service after 06/30/2008 CDO claims (other than for MFP members) are priced as follows:</p> <p>Procedure code T2040 uses the MAXFEE pricing method. The MAXFEE pricing method obtains the rate for the procedure code from the Max Fee panel using rate type MX1 for the claim date of service. The rate is multiplied by the units of service on the detail and this value is compared to the billed amount. Reimbursement is the lesser of the two (less other insurance, if any).</p> <p>For CDO claims procedure code T2022 must be submitted with an HI modifier. T2022HI uses the UCBILL pricing method. The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for rate type SC6 for ABI LTC Waiver members and SC5 for all other members for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance <u>and patient liability</u>, if any).</p>

	<p>For CDO claims procedure code T1028 must be billed with an SC modifier. T1028SC uses the UCBILL pricing method. The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for rate type SC5 (for all members – not just Michelle P) for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance, if any).</p> <p>All other procedure codes pay 100% of the detail billed amount (less other insurance, if any). Note – Procedure codes T2019, S5108, and T1999 allow 100% of the billed amount until the dollar limit on the prior authorization (PA) is reached (monitored by PA Edit 3006). Only the authorized dollar amount will be placed on PAs for these procedure codes. Units of service will not be placed on the PA and will not be considered in the pricing. Once the prior authorized dollar amount is reached for these codes, no additional payment will be made. For example, if the PA for one of the codes has a remaining balance of \$50.00 and the provider bills \$75.00, the allowed amount will be cut back to the remaining \$50.00. If a claim is submitted and the remaining balance is zero, the claim will be denied.</p> <p>Money Follows the Person (MFP) Claims</p> <p>For claims submitted for members with an MFP assignment plan (including CDO) the MAXFEE pricing method is used for all applicable SCL procedure codes with the exception of E1399, S5108, T2019 and E1999. The MAXFEE pricing method obtains the rate for the procedure code from the Procedure Max Fee panel for rate type “MFP” for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance <u>and patient liability</u>, if any).</p> <p>Procedure codes E1399, S5108, T2019, and T1999 allow 100% of the billed amount until the dollar limit on the prior authorization is reached (monitored by PA Edit 3006). Only the authorized dollar amount will be placed on PAs for these procedure codes. Units of service will not be placed on the PA and will not be considered in the pricing. Once the prior authorized dollar amount is reached for these codes, no additional payment will be made.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA:</p> <p>T2019, S5108, T1999, E1399</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.24 Claim Type M: Community Mental Health (Prov Type 30)

Alpha Claim Type	M (formerly Legacy U)	Provider Type	30
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Provider Contract	COMMH	Reimbursement Classification	RC Comm Mental Healt
Methodology/Logic	<p>Community Mental Health claims will price using the pricing method: UCBILL (UCC Billing Provider)</p> <p>Pricing Method(s):</p> <p>The UCBILL pricing method will obtain the rate for the service (i.e. procedure code and modifier combination) from the Customary Charge panel (Provider), for the rate type (CM1), (CM2), (CM3) for the date or service (from the claim). The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and patient liability, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>Example:</p> <p>Procedure code = 90801; modifier = AH, AJ, GC, HO, TD, U2, U3, U5, U6, U7, U8, U9, UA, UB, UC, U1, or AM without the UD modifier and none of these modifiers repeated and the modifier type for = AH, AJ, GC, HO, TD, U2, U3, U5, U6, U7, U8, U9, UA, UB, UC, U1, or AM is overridden to pricing, the rule with rate type CM1 will be used.</p> <p>Procedure code = 90801; modifier = SA without the UD modifier or a second SA modifier and the modifier type for SA is overridden to pricing, the rule with rate type CM2 will be used.</p> <p>Procedure code = 90801; modifier = AH, AJ, GC, HO, TD, U2, U3, U5, U6, U7, U8, U9, UA, UB, UC, U1, or AM and the UD modifier and none of these modifiers repeated and the modifier type for = AH, AJ, GC, HO, TD, U2, U3, U5, U6, U7, U8, U9, UA, UB, UC, U1, or AM, and UD is overridden to pricing, the rule with rate type CM3 will be used.</p>		
Exceptions	There are no exceptions.		

4.9.25 Claim Type M: Durable Medical Equipment Supplier (DME) (Prov Type 90)

Alpha Claim Type	M (formerly Legacy U)	Provider Type	90
Provider Contract	DME	Reimbursement Classification	Standard
Methodology/Logic	<p>Durable Medical Equipment (DME) claims will price using the following pricing methods:</p> <p>MAXFEE (Max Fee)</p> <p>LPAALW (Lesser PA/Max Fee Price)</p> <p>SYSMAN (System Manual Price)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method is used for services not requiring prior authorization. This pricing method uses a rate type of MX1 for the date of service. The MX1 rates are maintained on the Procedure Max Fee panel. The MX1 rate is multiplied by the units of service on the detail. The product is compared to the billed amount and reimbursement is the lesser of the two (less other insurance, coinsurance, and spenddown, if any).</p> <p>The LPAALW pricing method is used for services requiring prior authorization (other than E1399). Services requiring PA will have a “Y” PA indicator on the provider contract for the provider (DME). This pricing method uses a rate type of P90 for rentals and MX1 for purchased items. The P90 and MX1 rates are maintained on the Procedure Max Fee panel. The LPAALW pricing method compares the unit prior authorized amount (total amount divided by authorized units) to the Max Fee for the service (i.e. procedure code). The lesser of the two is multiplied by the detail units of service and reimbursement is determined by comparing the product to the detail billed amount. Reimbursement is the lesser of the two (less other insurance, coinsurance, and spenddown, if any). Please note that procedure codes submitted with a modifier of RR (Rental) or a combination of RR and QG modifiers (CO #11067) use the P90 rates that include these modifier/modifier combinations.</p> <p>The SYSMAN pricing method is used for procedure code E1399. This pricing method will check to see if a prior authorization (PA) is available to price the claim based on the PA submitted on the claim. If the pricing method for the PA is "pay unit fee price", then the unit rate will be multiplied by the number of units allowed on the detail. The lesser of the calculated allowed amount and the billed amount will be paid (less other insurance, coinsurance, and spenddown, if any). If there is not a PA price available, the claim will suspend for manual pricing (Edit 6000).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA:</p>		

	All services requiring PA Additional Reimbursement Info: None
Exceptions	There are no exceptions.

4.9.26 Claim Type M: Family Planning (Prov Type 32)

Alpha Claim Type	M (formerly Legacy U)	Provider Type	32
Provider Contract	FPLAN	Reimbursement Classification	RC Family Planning
Methodology/Logic	<p>Family Planning claims will price using the pricing method:</p> <p>MAXFLT (Max Flat Fee)</p> <p>MAXFEE (Max Fee)</p> <p>MANUAL (Manual)</p> <p>Pricing Method(s):</p> <p>The MAXFLT pricing method will obtain the rate for the service (i.e. procedure code and modifier combination) from the Max Fee panel, for the rate type (FP1) for the date of service (from the claim). The rate obtained is not multiplied by the units of service on the detail. The reimbursement is the lesser of the rate obtained or the billed amount (less other insurance and spenddown, if any).</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (FPO), (MX1) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>The MANUAL pricing method will be manual priced by the user.</p> <p>Pricing Method (10/16/2003 – 12/31/2299):</p> <p>The MAXFLT pricing method is used for all services except 99429.</p> <p><u>If the service is 99429 (procedure code)</u></p> <p>The MANUAL pricing method will be used.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p>		

	<p>Additional Reimbursement Info: None</p> <p>Pricing Method (Prior to and on 10/15/2003): The MAXFEE pricing method is used for all services.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.27 Claim Type M: Independent Laboratory (Prov Type 37)

DMS Approved 10/22/2009

Alpha Claim Type	M (formerly Legacy U)	Provider Type	37
Provider Contract	LAB	Reimbursement Classification	Standard
Methodology/Logic	<p>Independent Lab claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate type PSO for the claim date of service. The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service or if the applicable rate has an amount of zero, default pricing logic will be preformed. The reimbursement is 65% of the billed amount.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.9.28 **Claim Type M: Nurse Anesthetist (Prov Type 74)**

DMS approved 7/07/2008.

Alpha Claim Type	M (formerly Legacy U)	Provider Type	74
Provider Contract	CRNA	Reimbursement Classification	Standard
Methodology/Logic	<p>Nurse Anesthetist claims will price using the pricing methods:</p> <p>MAXFEE (Max Fee)</p> <p>ANESTH (dates of service after 06/30/2007)</p> <p>Pricing Method(s):</p> <p>The <u>MAXFEE pricing method</u> will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (P4I), (P4O) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>If the place of service (POS) is 21, 24, 51, 61 or 62 for the service, the P4I rate type is used.</p> <p>If the place of service (POS) is other than 21, 24, 51, 61 or 62 for the service, the P4O rate type is used.</p> <p>The <u>ANESTH pricing method</u> will obtain a base rate (rate type = ANE) and ASA Relative Value units for the procedure code from the Max Fee panel for the procedure code/date of service and apply the following formula:</p> <p>Base Rate X [ASA RVU* + (Units of Service / 15)] X 75% = Medicaid Allowed Amount.</p> <p>Medicaid reimbursement will be the lesser of the formula amount and the billed amount, less other insurance and spenddown, if any.</p> <p>*If ASA Relative Value units equal zero for the procedure/date of service, the anesthesia formula will not be used and the allowed amount will be computed by multiplying the billed amount by 45%.</p> <p>Note – Prior to the 5010 implementation (01/01/2012) providers billed in 15-minute increments so the units of service were not divided by 15 as they are currently (CO 16811).</p> <p>Note – the ANESTH pricing method is only used for dates of service after 06/30/2007 and is not used for every anesthesia procedure code. Please refer to additional anesthesia pricing criteria later in this section for further information.</p> <p>For dates of service after 06/30/2007 anesthesia procedures (00100-</p>		

	<p>01999), with the exception of those listed below, are priced using the ANESTH pricing method and associated formula discussed previously in this section.</p> <p>The following anesthesia procedure codes pay using the MAXFEE pricing method described previously in this section: 01960, 01961, 01967, 01968, 01969. Note – these procedure codes are limited to 1 unit of service.</p> <p>The following anesthesia procedure codes pay 33.75% of the billed amount:</p> <p>00539, 00548, 00561, 00580, 00604, 00754, 00756, 00796, .00836, 00868, 00950, 01150, 01160, 01170, 01670, 01680, 01782, 01925, 01953, 01962, 01966, 01996, 01999.</p> <p>Anesthesia procedures for dates of service prior to 07/01/2007 are priced using the MAXFEE pricing method discussed previously in this section. Anesthesia procedures for dates of service prior to 07/01/2007 are limited to 1 unit of service.</p> <p>Default Pricing Logic (MAXFEE only): If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be performed.</p> <p><u>If the place of service (POS) is 21, 24, 51, 61 or 62</u></p> <p>AND the date of service (DOS) is 12/13/1994 – 12/31/2299, the reimbursement is 50% of the billed amount.</p> <p><u>If the place of service (POS) is other than 21, 24, 51, 61 or 62</u></p> <p>AND the date of service (DOS) is 12/13/1994 – 12/31/2299, the reimbursement is 65% of the billed amount.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>A Benefit Adjustment Factor (BAF) is used for all services with the exception of J-codes, Q4083-Q4085, and S0180 (CO #10071). This reduction factor will also be applied to the product of (default rate X billed amount) when a rate is not found for a service. The BAF is 75%.</p>
<p>Exceptions</p>	<p>There are no exceptions.</p>

4.9.29 **Claim Type M: Nurse Practitioner (Prov Type 78)**

DMS approved 08/12/2012

Alpha Claim Type	M (formerly Legacy U)	Provider Type	78
Provider Contract	NPRCT	Reimbursement Classification	RC Professional Svcs
Methodology/Logic	<p>Nurse Practitioner claims will price using the pricing methods:</p> <p>MAXFEE (Max Fee)</p> <p>ANESTH</p> <p>Pricing Method(s):</p> <p>The <u>MAXFEE pricing method</u> will obtain the rate for the service (i.e. procedure code and/or modifier combination) from the Max Fee panel, for the rate type for the claim date of service. The rate is multiplied by the units of service on the detail. This value is multiplied by 75% (see “Additional Reimbursement Info” below) and the product is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay amount and other insurance and spenddown, if any).</p> <p>Rate type P4I is used for procedure codes (other than Lab) billed with a place of service code of 21, 24, 51, 61, or 62. Rate type P4O is used for procedure codes (other than Lab) billed with a place of service code other than 21, 24, 51, 61, or 62.</p> <p>Note - If a rate is not found for the procedure code for the date of service or if the applicable rate has an amount of zero, default pricing logic (explained later in this section) will be performed.</p> <p>The <u>ANESTH pricing method</u> is used for anesthesia pricing and will obtain a base rate (rate type = ANE) and ASA Relative Value units for the procedure code from the Max Fee panel for the procedure code/date of service and apply the following formula:</p> <p>Base Rate X [ASA RVU* + (Units of Service / 15)] X 75% = Medicaid Allowed Amount. Note – see “Additional Reimbursement Info” below for more information regarding the “X 75%” portion of the pricing formula.</p> <p>Medicaid reimbursement will be the lesser of the formula amount and the billed amount, less other insurance and spenddown, if any.</p> <p>Note – Prior to the 5010 implementation (01/01/2012) providers billed in 15-minute increments so the units of service were not divided by 15 as they are currently (CO 16811).</p> <p>Note – the ANESTH pricing method is not used for procedure code 01953. This code pays 33.75% of the billed amount, less other insurance and spenddown, if any.</p>		

<p>*If ASA Relative Value units equal zero for the procedure/date of service, the anesthesia formula will not be used and the allowed amount will be computed by multiplying the billed amount by 33.75% (the default rate of 45% X 75%).</p> <p><u>Lab Services (80000 – 89999)</u></p> <p>Lab codes will use the MAXFEE pricing method and the PSO rate type.</p> <p><u>Pathology Codes – listed near the end of this section</u></p> <p>If the DOS is 10/1/2002 – 12/31/2299. Pathology codes will use the MAXFEE pricing method and the P4O rate type.</p> <p>If the DOS is Prior to and on 9/30/2002. Pathology codes will use the MAXFEE pricing method and the PSO rate type.</p> <p><u>Professional Component (modifier 26)</u></p> <p>Services billed with a professional component will use the MAXFEE pricing method and will use the DEF rate type.</p> <p><u>Technical Component (modifier TC)</u></p> <p>Services billed with a technical component will use the MAXFEE pricing method and will use the DEF rate type.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service or if the applicable rate has an amount of zero, default pricing logic will be performed.</p> <p style="text-align: center;"><u>Dates of Service 08/01/2006 and After</u></p> <p>If the date of service is 08/01/2006 or after and the procedure code is submitted <u>without</u> modifier 26 or TC, the reimbursement is 33.75% (75% of Physician default rate of 45%) of the billed amount.</p> <p style="text-align: center;"><u>Dates of Service prior to 08/01/2006</u></p> <p>If the place of service is 21, 24, 51, 61 or 62, the procedure code is submitted <u>without</u> modifier 26 or TC, and the date of service is prior to 08/01/2006, the reimbursement is 37.5% (75% of 50%) of the billed amount.</p> <p>If the place of service is <u>other than</u> 21, 24, 51, 61 or 62, the procedure code is submitted without modifier 26 or TC, and the date of service is prior to 08/01/2006, the reimbursement is 48.75% (75% of 65%) of the billed amount.</p> <p style="text-align: center;"><u>Professional Component (modifier 26)</u></p> <p>If there is no professional component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab and pathology service codes.</p> <p style="text-align: center;"><u>Technical Component (modifier TC)</u></p> <p>If there is no technical component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab and pathology service</p>

	<p>codes.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>A Benefit Adjustment Factor (BAF) reducing the allowed amount by 25% is used for all services with the exception of vaccine codes 90476 - 90743, J-codes, Q4083-Q4085, S0180 (CO 10071), and 95120, 95125 (CO 14700) and A4264 (CO 15967). This reduction factor (allowed X 75%) will also be applied to the product of (default rate X billed amount) when a rate is not found for a service.</p> <p><u>Assistance at Surgery</u></p> <p>Identified by modifier 80 or 82. These modifiers are set up as processing modifiers and percentage (16%) this information can be found on the Modifier panel.</p> <p><u>Bilateral Procedures</u></p> <p>Identified by modifier 50. This modifier is set up as processing modifiers and percentage</p> <p>150% - for DOS 8/1/2006 – 12/31/2299</p> <p>200% - for DOS prior to and on 7/31/2006</p> <p>This information can be found on the Modifier panel.</p> <p>With the exception of procedure codes 64470, 64472, 64475, 64476, 64479, 64480, 64483, and 64484 (per CO 9699), if the units of service is greater than 1, the bilateral percentage is not applied. Reimbursement rules exist for this situation.</p> <p>Also, if the service is procedure codes (00100 – 01999), the bilateral percentage is not applied. Reimbursements rules exist for this situation.</p> <p><u>Physician Assistant</u></p> <p>Identified by modifier U1 (DOS – 10/16/2003 – 12/31/2299)</p> <p>Identified by modifier PA (DOS – Prior to and on 10/15/2003)</p> <p>These modifiers (U1, PA) are set up as processing modifiers and percentage (75%).</p> <p><u>Multiple Surgery</u></p> <p>The special pricing factor for claims with multiple surgical procedures performed on the same date of service is 100% for the highest service of all the possible multiple surgical services and 50% for every service considered a multiple surgery service on the same claim with the same date of service.</p> <p>If the units of service billed for the highest multiple surgical procedure is greater than one, one unit will price at 100% and the units exceeding one will</p>
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	<p>price at 50% per CO 16402 (see note below).</p> <p>The list of services (i.e. procedure codes) for multiple surgery reduction are maintained by the following procedure groups:</p> <p>3073 (KY Medical Procedures 1 – effective 1/1/1900 – 12/31/2299)</p> <p>3074 (KY Medical Procedures 2 – effective 1/2/2004 – 12/31/2299)</p> <p>3075 (KY Medical Procedures 3 – effective 1/1/1900 - 1/1/2004)</p> <p>The list of services (i.e. procedure codes) excluded from the multiple surgery reduction are maintained by the following procedure groups:</p> <p>3013 (KY Medical Proc Exclusions 1 - effective 1/2/2004)</p> <p>3014 (KY Medical Proc Exclusions 2 - effective prior to and on 1/2/2004)</p> <p>This can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p>If a detail has a modifier of 26, it is excluded from the multiple surgery reduction.</p> <p>NOTE: MULTIPLE SURGERIES PRICING BEFORE CO 16402: If two surgeries are performed by the same physician on the same date of service and one is excluded, the multiple surgeries factor is applied to either procedure. This also applies if more than two surgeries are performed and one or more is excluded.</p> <p>NOTE: MULTIPLE SURGERIES PRICING PER CO 16402: Multiple surgeries pricing will apply when one non-excluded surgical procedure is billed with units of service greater than one or when two or more non-excluded surgical procedures are on the same claim with the same date of service.</p> <p>If the claim has a modifier of 80 or 82 (assistant surgery) involving multiple surgeries on the same date of service, the assistant surgery factor is applied before multiple surgery factor.</p>																																																								
<p>Pathology Procedure Codes</p>	<p>Listing of Pathology Services</p> <table border="1"> <tr> <td>80500</td> <td>80502</td> <td>85060</td> <td>85095</td> <td>85097</td> <td>85102</td> <td>85390</td> <td>86077</td> </tr> <tr> <td>86078</td> <td>86079</td> <td>86485</td> <td>86490</td> <td>86510</td> <td>86580</td> <td>86585</td> <td>86586</td> </tr> <tr> <td>88104</td> <td>88106</td> <td>88107</td> <td>88108</td> <td>88112</td> <td>88120</td> <td>88121</td> <td>88125</td> </tr> <tr> <td>88141</td> <td>88160</td> <td>88161</td> <td>88162</td> <td>88170</td> <td>88171</td> <td>88172</td> <td>88173</td> </tr> <tr> <td>88177</td> <td>88180</td> <td>88182</td> <td>88291</td> <td>88300</td> <td>88302</td> <td>88304</td> <td>88305</td> </tr> <tr> <td>88307</td> <td>88309</td> <td>88311</td> <td>88312</td> <td>88313</td> <td>88314</td> <td>88318</td> <td>88319</td> </tr> <tr> <td>88321</td> <td>88323</td> <td>88325</td> <td>88329</td> <td>88331</td> <td>88332</td> <td>88342</td> <td>88346</td> </tr> </table>	80500	80502	85060	85095	85097	85102	85390	86077	86078	86079	86485	86490	86510	86580	86585	86586	88104	88106	88107	88108	88112	88120	88121	88125	88141	88160	88161	88162	88170	88171	88172	88173	88177	88180	88182	88291	88300	88302	88304	88305	88307	88309	88311	88312	88313	88314	88318	88319	88321	88323	88325	88329	88331	88332	88342	88346
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88177	88180	88182	88291	88300	88302	88304	88305																																																		
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88321	88323	88325	88329	88331	88332	88342	88346																																																		

	88347	88348	88349	88355	88356	88358	88361	88362
	88363	88365	88367	88380	88381	88384	88385	88386
	88387	88388	88399	89100	89105	89130	89132	89135
	89136	89140	89141	89136	89140	89141	89350	89360
	<p>Procedure codes 88120, 88121, 88177 and 88363 added to list of Pathology codes per CO 15370.</p> <p>Procedure code 88367 added to list of Pathology codes effective with date of service 01/01/2011 per CO 15411.</p> <p>Procedure codes 88380, 88381, 88384 – 88388 and 88399 added to list of Pathology codes per CO 17391.</p>							
“Brown Bagging” J-codes/NDCs	<p>For dates of service 07/01/2007 and after Brown Bagging drugs are submitted with a National Drug Code (NDC) and are priced using the following formula:</p> <p>[(AWP Rate minus 10%) X Drug Quantity</p> <p>Since multiple drugs can be billed for a particular claim detail, this formula is applied to every NDC on that claim detail. Their products are then added together and compared to the detail billed amount. Medicaid reimbursement is the lesser of the two.</p> <p>Brown bagging drugs have NDC codes and J-codes that are listed in the “NDC Group Type” table (J-code/NDC Cross-Reference) and can be viewed by selecting Related Data/Other, then NDC Group Type under the Reference Subsystem. AWP rates for a particular NDC are listed in the “AWUP” field and can be viewed on the Reference Drug panel by selecting “AWP Rates.” Rates are determined based on the detail from date of service.</p> <p>Note – If J-code J3590 is submitted with NDC 50242006001 or 50242006101, reimbursement is the lesser of the billed amount or the procedure code rate (units of service are <u>not</u> considered). Rate type P4I is used for details with a place of service code of 21, 24, 51, 61, or 62. Rate type P4O is used for details billed with a place of service code other than 21, 24, 51, 61, or 62.</p>							
Exceptions	There are no exceptions.							

4.9.30 Claim Type M: Other Lab & X-Ray (Prov Type 86)

Alpha Claim Type	M (formerly Legacy U)	Provider Type	86
Provider Contract	XRAY	Reimbursement Classification	RC Oth lab and X-ray
Methodology/Logic	<p>Other Lab & X-Ray claims will price using the pricing method: MAXFEE (Max Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code) from the Max Fee panel, for the rate types (P4O), (P4I), (PSO) for the date of service (from the claim). The rate is multiplied by the units of service on the detail and a Benefit Adjustment Factor (BAF) of 60% is applied. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be performed.</p> <p>If the place of service (POS) is 21 or 51, the rate is 50% of the billed amount.</p> <p>If the place of service (POS) is other than 21 or 51, the rate is 65% of the billed amount.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p>A Benefit Adjustment Factor (BAF) is used for all services. This will also be applied if a rate is not found for a service. The BAF is 60%.</p> <p>Example:</p> <p>For services billed with a place of service of (21 or 51), no rate found, and billed amount of \$100.00.</p> <p>Reimbursement equals \$30.00 = (\$100 x 50%) x 60%</p> <p>For services billed with a place of service of other than (21 or 51), no rate found, and billed amount of \$100.00.</p> <p>Reimbursement equals \$39.00 = (\$100 x 65%) x 60%</p>		
Exceptions	There are no exceptions.		

4.9.31 Claim Type M: Podiatry (Prov Type 80)

DMS Approved 07/08/2012

Alpha Claim Type	M (formerly Legacy Y)	Provider Type	80
Provider Contract	PODI	Reimbursement Classification	RC Professional Svcs
Methodology/Logic	<p>Podiatry claims will price using the pricing method:</p> <p>MAXFEE (Max Fee)</p> <p>Pricing Method(s):</p> <p>The MAXFEE pricing method will obtain the rate for the service (i.e. procedure code and/or modifier combination) from the Max Fee panel, for the rate type (P4O), (P4I), (PSO) for the date of service (from the claim). The rate is multiplied by the units of service on the detail. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay amount and other insurance and spenddown, if any).</p> <p><u>Lab Services (80000 – 89999)</u></p> <p>Lab codes will use the MAXFEE pricing method and the PSO rate type.</p> <p><u>Pathology Codes</u></p> <p>Pathology codes will use the MAXFEE pricing method and the P4O rate type.</p> <p><u>Professional Component (modifier 26)</u></p> <p>Services billed with a professional component will use the MAXFEE pricing method and will use the DEF rate type.</p> <p><u>Technical Component (modifier TC)</u></p> <p>Services billed with a technical component will use the MAXFEE pricing method and will use the DEF rate type.</p> <p>Default Pricing Logic: If a rate is not found for the service (i.e. procedure code) for the date of service, default pricing logic will be preformed.</p> <p><u>Non Lab Services</u></p> <p><u>If the place of service (POS) is 21, 24, 51, 61 or 62</u></p> <p>AND the date of service (DOS) is 7/2/1997 – 12/31/2299, the reimbursement is 50% of the billed amount.</p> <p><u>Non Lab Services</u></p>		

	<p><u>If the place of service (POS) is other than 21, 24, 51, 61 or 62</u></p> <p>AND the date of service (DOS) is 7/2/1994 – 12/31/2299, the reimbursement is 65% of the billed amount.</p> <p><u>Lab Services (80000 – 89999)</u></p> <p>If the service (i.e. procedure code) is a lab procedure code (80001 – 89399), the reimbursement is 65% of the billed amount. The lab services are maintained by a procedure group (3072 – ALL LABS) which can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p><u>Professional Component (modifier 26)</u></p> <p>If there is no professional component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab and pathology service codes.</p> <p><u>Technical Component (modifier TC)</u></p> <p>If there is no technical component rate for the procedure code, the (P4O) rate type will be used if available. This applies for lab and pathology service codes.</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>Assistance at Surgery</u></p> <p>Identified by modifier 80 or 82. These modifiers are set up as processing modifiers and percentage (16%) this information can be found on the Modifier panel.</p> <p><u>Bilateral Procedures</u></p> <p>Identified by modifier 50. This modifier is set up as processing modifiers and percentage</p> <p>150% - for DOS 8/1/2006 – 12/31/2299</p> <p>200% - for DOS prior to and on 7/31/2006</p> <p>this information can be found on the Modifier panel.</p> <p>If the units of service are greater than 1, the bilateral percentage is not applied. Reimbursements rules exists for this situation.</p> <p>Also, if the service is procedure codes (00100 – 01999), the bilateral percentage is not applied. Reimbursements rules exists for this situation.</p> <p><u>Multiple Surgery</u></p> <p>The special pricing factor for claims with multiple surgical procedures performed on the same date of service is 100% for the highest service of all the possible multiple surgical services and 50% for every service</p>
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	<p>considered a multiple surgery service on the same claim with the same date of service.</p> <p>If the units of service billed for the highest multiple surgical procedure is greater than one, one unit will price at 100% and the units exceeding one will price at 50% per CO 16402 (see note below).</p> <p>The list of services (i.e. procedure codes) for multiple surgery reduction are maintained by the following procedure groups:</p> <p>3073 (KY Medical Procedures 1 – effective 1/1/1900 – 12/31/2299)</p> <p>3074 (KY Medical Procedures 2 – effective 1/2/2004 – 12/31/2299)</p> <p>3075 (KY Medical Procedures 3 – effective 1/1/1900 - 1/1/2004)</p> <p>The list of services (i.e. procedure codes) excluded from the multiple surgery reduction are maintained by the following procedure groups:</p> <p>3013 (KY Medical Proc Exclusions 1 - effective 1/2/2004)</p> <p>3014 (KY Medical Proc Exclusions 2 - effective prior to and on 1/2/2004)</p> <p>this can be found on the HCPCS Procedure Grp Typ panel (Reference subsystem).</p> <p>If a detail has a modifier of 26, it is excluded from the multiple surgery reduction.</p> <p>NOTE: MULTIPLE SURGERIES PRICING BEFORE CO 16402: If two surgeries are performed by the same physician on the same date of service and one is excluded, the multiple surgery factor is applied to either procedure. This also applies if more than two surgeries are performed and one or more is excluded.</p> <p>NOTE: MULTIPLE SURGERIES PRICING PER CO 16402: Multiple surgeries pricing will apply when one non-excluded surgical procedure is billed with units of service greater than one or when two or more non-excluded surgical procedures are on the same claim with the same date of service.</p> <p>If the claim has a modifier of 80 or 82 (assistant surgery) involving multiple surgeries on the same date of service, the assistant surgery factor is applied before multiple surgery factor.</p>
Exceptions	There are no exceptions.

4.9.32 **Claim Type M: Acquired Brain Injury – (ABI) (Prov Type 17)**

DMS Approved

Alpha Claim Type	M (formerly Legacy E)	Provider Type	17
Provider Contract	ABIWV ABICD	Reimbursement Classification	ABI Waiver ABI Waiver CDO
Methodology/Logic	<p>ABI claims will price using the pricing method:</p> <p>UCBILL</p> <p>MANUAL</p> <p>BILLED</p> <p>Pricing Method(s):</p> <p>For claims other than Consumer Directed Option and MFP, the UCBILL pricing method is used for all ABI procedure codes with the exception of S5165, T2029 and E1399. The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for the date of service using rate type AB2 for ABI LTC Waiver member claims and AB1 for all others. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and patient liability, if any).</p> <p>Procedure code S5165 for dates of service 05/01/2009 and after pays 100% of the billed amount until the dollar limit on the prior authorization (PA) is reached (monitored by PA Edit 3006). Other insurance and patient liability, if any, are deducted. For dates of service prior to 05/01/2009 S5165 is manually priced. The BILLED pricing method is used to reimburse a detail at 100% of the detail billed amount on the claim. The MANUAL pricing method is used to suspend the claim for manual pricing (ESC 6000).</p> <p>Procedure codes T2029 and E1399 pay 100% of the billed amount until the dollar limit on the prior authorization (PA) is reached (monitored by PA Edit 3006). Other insurance and patient liability, if any, are deducted. The BILLED pricing method is used to reimburse a detail at 100% of the detail billed amount on the claim.</p> <p><u>Consumer Directed Option (CDO) Claims</u></p> <p>For dates of service prior to 07/01/2008 CDO claims paid 100% of the billed amount (less other insurance, if any). Patient liability is not deducted from CDO claims with dates of service prior to 07/01/2008.</p> <p>For dates of service after 06/30/2008 CDO claims (other than for MFP members) are priced as follows:</p> <p>Procedure code T2040 uses the MAXFEE pricing method. The MAXFEE</p>		

pricing method obtains the rate for the procedure code from the Max Fee panel using rate type MX1 for the claim date of service. The rate is multiplied by the units of service on the detail and this value is compared to the billed amount. Reimbursement is the lesser of the two (less other insurance, if any).

For CDO claims procedure code T2022 must be submitted with an HI modifier. T2022HI uses the UCBILL pricing method. The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for rate type AB2 for ABI LTC members and AB1 for all other members for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and patient liability, if any).

For CDO claims procedure code T1028 must be submitted with an SC modifier. T1028SC uses the UCBILL pricing method. The UCBILL pricing method obtains the rate for the procedure code from the Provider Customary Charge panel for rate type AB2 for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance, if any).

All other procedure codes pay 100% of the detail billed amount (less other insurance, if any). Note – Procedure codes T2019, S5108, and T1999 allow 100% of the billed amount until the dollar limit on the prior authorization (PA) is reached (monitored by PA Edit 3006). Only the authorized dollar amount will be placed on PAs for these procedure codes. Units of service will not be placed on the PA and will not be considered in the pricing. Once the prior authorized dollar amount is reached for these codes, no additional payment will be made. For example, if the PA for one of the codes has a remaining balance of \$50.00 and the provider bills \$75.00, the allowed amount will be cut back to the remaining \$50.00. If a claim is submitted and the remaining balance is zero, the claim will be denied.

Money Follows the Person (MFP) Claims

For claims submitted for members with an MFP assignment plan (including CDO) the MAXFEE pricing method is used for all ABI procedure codes with the exception of E1399, S5108, T2019 and E1999. The MAXFEE pricing method obtains the rate for the procedure code from the Procedure Max Fee panel for rate type “MFP” for the claim date of service. The rate is multiplied by the units of service on the detail. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and patient liability, if any).

Procedure codes E1399, S5108, T2019, and T1999 allow 100% of the billed amount until the dollar limit on the prior authorization is reached (monitored by PA Edit 3006). Only the authorized dollar amount will be placed on PAs for these procedure codes. Units of service will not be placed on the PA and will not be considered in the pricing. Once the prior

	<p>authorized dollar amount is reached for these codes, no additional payment will be made.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: S5108, T1999, T2019, S5165, E1399</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.9.33 Claim Type M: Money Follows the Person (MFP) Pre-Transition Services (Prov Type 14)

Alpha Claim Type	M	Provider Type	14
Provider Contract	MFPTS	Reimbursement Classification	Standard
Methodology/Logic	<p>MFP Pre-Transition Services claims will price using the pricing method: BILLED (Pay Billed Amount)</p> <p>Pricing Method(s):</p> <p>The BILLED pricing method will reimburse the detail billed amount on the claim. Only three procedure codes are payable – S5165, T2035, and T2038. Note – patient liability is not deducted from MFP Pre-Transition claims.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.10 Claim Type O

4.10.1 Claim Type O: Renal Dialysis (Prov Type 39)

Alpha Claim Type	O (formerly Legacy M)	Provider Type	39
Provider Contract	DLYIS	Reimbursement Classification	RC Renal Dialysis
Methodology/Logic	<p>Renal Dialysis claims price using the pricing method:</p> <p>PPRUNT (Provider Priced Unit)</p> <p>REVMXF (Rev Max Fee/Compare to Billed)</p> <p>REVMX1 (Rev Max Fee/No Compare To Billed)</p> <p>PPRPCT (Provider Priced Percent)</p> <p>Pricing Method(s):</p> <p>The PPRUNT pricing method will get the provider's specific rate using rate types RD1, RD3, RD4, RD5 (based on revenue code) for the claim detail date of service. The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units on the claim. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>The REVMXF pricing method will get the Max Fee for the <u>procedure code</u> submitted with the revenue code on the claim detail. The Max Fee rate can be found on the Max Fee panel (Reference subsystem) using the rate type of PSO for the date of service on the claim detail. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>The PPRPCT pricing method will get the provider's specific percentage rate using the RD2 rate type for the date of service on the claim (detail). The provider's specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less other insurance and spenddown, if any).</p> <p>The REVMX1 pricing method will get the Max Fee for the <u>procedure code</u> submitted with the revenue code on the claim detail. The Max Fee rate can be found on the Max Fee panel (Reference subsystem) using the rate type of RD6 for the date of service on the claim detail. The rate is multiplied by the units to determine the Medicaid Allowed Amount. The allowed amount is NOT compared to the billed amount. Reimbursement is the allowed amount less other insurance and spenddown, if any.</p>		

	<p><u>Revenue Codes 821, 831, 841, 851</u></p> <p>These services will use the PPRUNT pricing method with a rate type of RD1 (821), RD3 (831), RD4 (834), or RD5 (835).</p> <p><u>Revenue Codes 300 - 314 with procedure Code 36415, 80001 – 89399.</u> <u>Procedure codes G0433 – G0435, G9143 and Q0115 added per CO 15266.</u></p> <p>These services will use the REVMXF pricing method with a rate type of PSO.</p> <p><u>Revenue Codes 250, 270, 320, 632, 634, 635, 730, 855, 920</u></p> <p>These services will use the PPRPCT pricing method with a rate type of RD2.</p> <p><u>Revenue Code 636</u></p> <p>For dates of service 06/01/2007 and after this revenue code will price using the REVMX1 pricing method and a rate type of RD6 (per CO #8061). Note – only certain procedure codes are billable with revenue code 636.</p> <p>For dates of service prior to 06/01/2007, this revenue code will price using the PPRPCT pricing method with a rate type of RD2.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.10.2 Claim Type O: Outpatient Hospital (Prov Type 01)

Alpha Claim Type	O (formerly Legacy M)	Provider Type	01
Provider Contract	OPHOS (Outptnt Hosp) NACOP (Critical Access) PT – 01 UNVOP (University Hosp)	Reimbursement Classification	RC Outpatient Hosp
Methodology/Logic	Outpatient Hospital claims will price using the pricing method: PPRPCT (Provider Priced Percentage) REVMXF (Revenue Max Fee)		

Note – Flat rate pricing, described later in this manual, is currently applied to claims with dates of service of 09/01/2002 through 01/04/2009. Change order 10857 (implemented 01/01/2012) removed Flat Rate pricing for dates of service after 01/04/2009. Claim with dates of service after 01/05/2009 that formerly would have been reimbursed using the flat rate pricing are now priced using the criteria in this section.

Pricing Method:

The PRRPCT pricing method will get the provider's specific percentage rate using the (OP1), (OP2) rate type for the date of service on the claim (detail). The provider's specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, patient liability and other insurance, if any).

The REVMXF pricing method will get the Max Fee for the procedure code submitted with the revenue code on the claim detail. The Max Fee rate can be found on the Max Fee panel (Reference subsystem) using the rate type of (PSI), (PSO) for the date of service on the claim detail. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, patient liability and other insurance, if any).

Default Pricing Logic: None

Pricing Method - Services which price from PA: None

Additional Reimbursement Info:

If the service is 300 - 314 (Revenue Code)

AND the type of bill (TOB) is **141**

AND the DOS is 9/1/2003 – 12/31/2299, then the REVMXF pricing method and the PSO are used. The revenue code **does** require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.

AND the DOS is prior to or on 8/31/2003, then the REVMXF pricing method and the PSO are used. The revenue code **does not** require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.

If the service is 300 - 314 (Revenue Code)

AND the type of bill (TOB) is **131, 721, 831**

AND the DOS is 9/1/2003 – 12/31/2299, then the REVMXF pricing method and the PSI are used. The revenue code **does** require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.

	AND the DOS is prior to or on 8/31/2003, then the REVMXF pricing method and the PSI are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.
Exceptions	There are no exceptions.

4.10.3 Claim Type O: Outpatient Hospital (Prov Type 01) “Flat Rate” Claims (Dates of Service 08/04/2003 through 01/04/2009)

Alpha Claim Type	O (formerly Legacy M)	Provider Type	01
Provider Contract	OPHOS (Outptnt Hosp) Prov Type – 01 Prov Spec - 014 UNVOP (University Hosp)	Reimbursement Classification	RC Outpatient Hosp
Methodology/Logic	<p>Outpatient Hospital “Flat Rate” claims will price using the pricing method:</p> <p>FLTFEE (Flat Fee)</p> <p>PPRPCT (Provider Priced Percnt)</p> <p>REVUNT (Revenue Unit)</p> <p>ZEROPD (Zero Paid)</p> <p>OPASC (Ambulatory Surgical Cntr)</p> <p>Note – Flat rate pricing only applies to claims with dates of service of 08/04/2003 through 01/04/2009. Change order 10857 (implemented 01/01/2012) removed ‘Flat Rate’ pricing for dates of service after 01/04/2009. For dates of service of 01/05/2009 and after these claims use the PPRPCT and REVMXF pricing logic documented in the “Outpatient Hospital” section above.</p> <p>Pricing Method:</p> <p>The FLTFEE pricing method will get the revenue code flat rate using the (OP3), (OP5), (OP6) rate type for the date of service on the claim (detail). The specific revenue flat fee can be found on the Flat Fee panel (Reference subsystem) for that revenue code. The rate is not multiplied by the units on the detail. The reimbursement is not cutback to the lesser of the billed or allowed amount (less copay, patient liability and other insurance, if</p>		

	<p>any).</p> <p>The PPRPCT pricing method will get the provider's specific percentage rate using the (OP1) rate type for the date of service on the claim (detail). The provider's specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, patient liability and other insurance, if any).</p> <p>The REVUNT pricing method will get the revenue code flat rate using the (OP4) rate type for the date of service on the claim (detail). The specific revenue flat fee can be found on the Flat Fee panel (Reference subsystem) for that revenue code. The rate is multiplied by the units which is the reimbursement (less copay, patient liability and other insurance, if any). This amount is not compared to the billed amount.</p> <p>The ZEROPD pricing method will pay zero dollars. The status of the detail will be paid.</p> <p>The OPASC pricing method will get the ASC rate associated with the procedure code submitted with an operating room (OR) revenue code using the (OPA) rate type. Additional special pricing logic is triggered by this pricing method for outpatient claims containing ASC services.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>If the service is 278 (Revenue Code) w/ Procedure Code L8614</u></p> <p>AND the provider contract is University Hospital (01013978) (provider contract - UNVOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the PPRPCT pricing method and the OP1 are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.</p> <p>AND the DOS is 8/4/2003 – 8/31/2003, then the PPRPCT pricing method and the OP1 are used. The revenue code does require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.</p> <p><u>If the service is 278 (Revenue Code)</u></p> <p>AND the provider is a critical access provider (provider contract -</p>
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	<p>NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the PPRPCT pricing method and the OP1 are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p>AND the DOS is 8/4/2003 – 8/31/2003, then the PPRPCT pricing method and the OP1 are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p>AND the DOS is prior to or on 8/3/2003, then the PPRPCT pricing method and the OP1 are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p><u>If the service is 278 (Revenue Code)</u></p> <p>AND the provider is not a critical access provider (not a provider contract of – NACOP or UNVOP)</p> <p>AND the DOS is prior to or on 8/3/2003, then the PPRPCT pricing method and the OP1 are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p><u>If the service is 350, 351, 352, 610, 611, 612, 762, 790 (Revenue Code)</u></p> <p>AND the provider is not a critical access provider (not a provider contract of - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the FLTFEE pricing method and the OP3 rate type are used. The revenue code REQUIRES specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific services that apply.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the FLTFEE pricing method and the OP3 rate type are used. The revenue code REQUIRES specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific services that apply.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p>
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	<p><u>If the service is 350, 351, 352, 610, 611, 612, 762, 790 (Revenue Code)</u></p> <p>AND the provider is a critical access provider (provider contract - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code REQUIRES specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific services that apply.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code REQUIRES specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific services that apply.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p> <p><u>If the service is 333 (Revenue Code)</u></p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the PPRPCT pricing method and the OP1. The revenue code REQUIRES specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p>AND the DOS is prior or on 8/31/2003, then the PPRPCT pricing method and the OP1. The revenue code REQUIRES specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p><u>If the service is 402 (Revenue Code)</u></p> <p>AND the provider is not a critical access provider (not a provider contract of - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the REVUNT pricing method and the OP4 rate type are used. The revenue code REQUIRES specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the REVUNT pricing method and the OP4 rate type are used. The revenue code REQUIRES specific</p>
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<p>procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that applies.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p> <p><u>If the service is 402 (Revenue Code)</u></p> <p>AND the provider is a critical access provider (provider contract - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p> <p><u>If the service is 481 (Revenue Code)</u></p> <p>AND the provider is not a critical access provider (not a provider contract of - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the FLTFEE pricing method with the OP5, or OP6 rate type or the ZEROPD pricing method with the NA rate type are used. The OP5 and OP6 rates are found on the Revenue Code Panel in the Reference Subsystem.</p> <p>Revenue code 481 must be billed in conjunction with one of the following CPT codes to generate a payment. The flat rate is <u>not</u> multiplied by units of service.</p> <p>CPT codes 93501, 93508, 93510, 93514, 93530 allow \$1478.00. CPT codes 93451, 93452, 93455, 93458 and 93459 allow \$1478.00 per CO15374. CPT procedure code 93454 allow \$1478.00 per CO 16717.</p> <p>CPT codes 93511, 93524, 93526-93529, 93531-93533 allow \$1770.00. CPT codes 93453, 93456, 93457, 93460, and 93461 allow \$1770.00 per CO 15374.</p> <p>CPT codes 33217, 33223, 33225, 33240, 33244, 33249, 35226,</p>

37250, 37251, 75854, 90780, 92940, 92950, 92960, 92961, 92973, 92974, 92978, 92979, 92980, 92981, 92982, 92984, 92987, 92990, 93503, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 93555, 93556, 93571, 93572, 93580, 93600, 93609, 93613, 93620, 93621, 93622, 93623, 93624, 93631, 93640, 93641, 93642, 93650, 93651, 93652, G0269, G0290, G0291 allow zero. CPT codes 93454, 93462, 93463, and 93464 allow zero per CO 15374. CPT procedure code 93454 removed from zero pay per CO 16717.

AND the DOS is 9/1/2002 – 8/31/2003, then the FLTFEE pricing method and the OP5, or OP6 or the ZEROPD pricing method and the NA rate type are used. The revenue code **does** require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.

AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code **does not** require a specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.

If the service is 481 (Revenue Code)

AND the provider **is** a critical access provider (provider contract - NACOP)

AND the DOS is prior to or on 12/31/2299, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code **does not** require a specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.

If the service is 360 (Revenue Code)

AND the provider **is not** a critical access provider (not a provider contract of - NACOP)

AND the DOS is 9/1/2003 – 01/04/2009, then the OPASC pricing method and the OPA rate type or the PPRPCT pricing method and the OP1 rate type are used. The revenue code **does** require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the

	<p>specific service (revenue/procedure code) that apply.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the OPASC pricing method and the OPA rate type or the PPRPCT pricing method and the OP1 rate type are used. The revenue code does require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p><u>If the service is 360 (Revenue Code)</u></p> <p>AND the provider is a critical access provider (provider contract - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service that apply.</p> <p><u>Additional service 360 (Revenue Code) info</u></p> <ol style="list-style-type: none">1. If the claim has one detail with revenue code 360 and that line is a groupable CPT code, the claim pays as follows:<ol style="list-style-type: none">a. Claim pays the 360 detail at the groupable rate.b. If there are other flat rate detail lines on the claim, these pay their flat rate fee.c. Laboratory details pay zero.2. If the claim has multiple details with revenue code 360 and it is a groupable CPT code, the claim pays as follows:<ol style="list-style-type: none">a. Claim pays the 360 detail with the highest groupable rate.
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	<p>b. If there are other flat rate detail lines on the claim, these pay their flat rate fee.</p> <p>c. Laboratory details pay zero.</p> <p>3. If the claim has one detail with revenue code 360 and it is a non groupable CPT code, the claim pays as follows:</p> <p>a. Claim pays the 360 detail and the non flat fee details using the OP1 rate type.</p> <p>b. If there are other flat rate detail lines on the claim, these pay at their flat rate fee and laboratory details pay zero.</p> <p>c. If there are no other flat fee details on the claim, pay the laboratory details at the appropriate lab rate.</p> <p>4. If the claim has multiple details with revenue code 360 and at least one is a non groupable CPT code, the claim pays as follows:</p> <p>a. For each non groupable detail 360, multiply all other non flat rate details except for laboratory by the OP1 rate type and add the laboratory details at their lab rate. Compare the results to each groupable 360 detail.</p> <p>b. If the highest 360 detail is a non groupable rate, then that detail and all non flat rate details pay at the OP1 rate type except for laboratory details. If there are no other flat rate details, the laboratory details pay at the appropriate lab rate. If there are other flat rate details on the claim, these pay their flat rate and laboratory details pay zero.</p> <p>c. If the highest 360 detail is a groupable rate, the claim pays that rate and laboratory pays zero. All other flat rate details pay at their flat rate.</p> <p>5. Revenue Code 360 submitted with dental procedure code (D0110 – D9999) pay using the OP1 rate type and has no bearing on the above scenarios. NOTE: Critical Access Hospitals billing revenue code 333 use the same pricing logic, but have a different contract.</p>
Exceptions	There are no exceptions.

4.10.4 Claim Type O: Outpatient Hospital Emergency Room (Prov Type 01) Flat Rate Claims With Revenue Code 450, 452, or 456 (Date of Service 09/01/2002 thru 01/04/2009)

Alpha Claim Type	O (formerly Legacy M)	Provider Type	01
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<p>Provider Contract</p>	<p>OPHOS (Outptnt Hosp) NACOP (Critical Access) Prov Type – 01 Prov Spec - 014 UNVOP (University Hosp)</p>	<p>Reimbursement Classification</p>	<p>RC Outpatient Hosp</p>
<p>Methodology/Logic</p>	<p>Outpatient Hospital Emergency Room claims will price using the pricing method:</p> <p>FLTFEE (Flat Fee) PPRPCT (Provider Priced Percent)</p> <p>Note – Flat rate pricing only applies to claims with dates of service of 09/01/2002 through 01/04/2009. Change order 10857 (implemented 01/01/2012) removed ‘Flat Rate’ pricing for dates of service after 01/04/2009. For dates of service of 01/05/2009 and after these claims use the PPRPCT and MAXFEE pricing logic documented in the “Outpatient Hospital” section above.</p> <p>Pricing Method:</p> <p>The FLTFEE pricing method will get the revenue code flat rate using the (OP3), (OP5), (OP6) rate type for the date of service on the claim (detail). The specific revenue flat fee can be found on the Flat Fee panel (Reference subsystem) for that revenue code. The rate is not multiplied by the units on the detail. The reimbursement is not cutback to the lesser of the billed or allowed amount (less copay, patient liability and other insurance, if any).</p> <p>The PPRPCT pricing method will get the provider’s specific percentage rate using the (OP1) rate type for the date of service on the claim (detail). The provider’s specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, patient liability and other insurance, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>If the service is 450, 452, 456 (Revenue Code)</u></p> <p>AND the provider is not a critical access provider (not a provider contract</p>		

	<p>of - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the FLTFEE pricing method and the OP3, OP5, or OP6 rate type are used. The revenue code does require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the FLTFEE pricing method and the OP3, OP5, or OP6 rate type are used. The revenue code does require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p> <p><u>If the service is 450, 452, 456 (Revenue Code)</u></p> <p>AND the provider is a critical access provider (provider contract - NACOP)</p> <p>AND the DOS is 9/1/2003 – 12/31/2299, then the PPRPCT pricing method and the OP1. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require specific procedure code to be billed with it on the claim. See the reimbursement rule(s) for the specific service (revenue/procedure code) that apply.</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The revenue code does not require a specific procedure code to be billed with it on the claim.</p>
Exceptions	There are no exceptions.

4.10.5 Claim Type O: Outpatient Hospital Emergency Room (Prov Type 01) Claims With Revenue Code 451 (Date of Service 09/01/2002 thru 01/04/2009)

Alpha Claim Type	O (formerly Legacy M)	Provider Type	01
Provider Contract	OPHOS (Outptnt Hosp) NACOP (Critical Access)	Reimbursement Classification	RC Outpatient Hosp

	Prov Type – 01 Prov Spec - 014 UNVOP (University Hosp)		
Methodology/Logic	<p>Outpatient Hospital Emergency Room claims will price using the pricing method:</p> <p>FLTFEE (Flat Fee)</p> <p>PPRPCT (Provider Priced Percent)</p> <p>Note – Flat rate pricing only applies to claims with dates of service of 09/01/2002 through 01/04/2009. Change order 10857 (implemented 01/01/2012) removed Flat Rate pricing for dates of service after 01/04/2009. For dates of service of 01/05/2009 and after these claims use the PPRPCT and MAXFEE pricing logic documented in the “Outpatient Hospital” section above.</p> <p>Pricing Method:</p> <p>The FLTFEE pricing method will get the revenue code flat rate using the (OP3) rate type for the date of service on the claim (detail). The specific revenue flat fee can be found on the Flat Fee panel (Reference subsystem) for that revenue code. The rate is not multiplied by the units on the detail. The reimbursement is not cutback to the lesser of the billed or allowed amount (less copay, patient liability and other insurance, if any).</p> <p>The PPRPCT pricing method will get the provider’s specific percentage rate using the (OP1) rate type for the date of service on the claim (detail). The provider’s specific percentage rate can be found on the Provider Rate panel for that provider. The percentage is multiplied by the detail billed amount. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less copay, patient liability and other insurance, if any).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info:</p> <p><u>If the service is 451 (Revenue Code)</u></p> <p>AND the provider is not a critical access provider (not a provider contract of - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the FLTFEE pricing method and the OP3 rate type are used. The reimbursement rule(s) will apply to both claim type O (outpatient) and C (outpatient crossover).</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the FLTFEE pricing method</p>		

	<p>and the OP3 rate type are used. The reimbursement rule(s) will apply to claim type O (outpatient).</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The reimbursement rule(s) will apply to claim type O (outpatient).</p> <p><u>If the service is 451 (Revenue Code)</u></p> <p>AND the provider is a critical access provider (provider contract - NACOP)</p> <p>AND the DOS is 9/1/2003 – 01/04/2009, then the PPRPCT pricing method and the OP1 rate type are used. The reimbursement rule(s) will apply to both claim type O (outpatient) and C (outpatient crossover).</p> <p>AND the DOS is 9/1/2002 – 8/31/2003, then the PPRPCT pricing method and the OP1 rate type are used. The reimbursement rule(s) will apply to claim type O (outpatient).</p> <p>AND the DOS is prior or on 8/31/2002, then the PPRPCT pricing method and the OP1 rate type are used. The reimbursement rule(s) will apply to claim type O (outpatient).</p>
Exceptions	There are no exceptions.

4.10.6 Claim Type O: Out Of State Transplant/Related Claims (Prov Type 01)

Alpha Claim Type	O (formerly Legacy M)	Provider Type	01
Provider Contract	OPHOS (Outptnt Hosp) NACOP (Critical Access) Prov Type - 01 Prov Spec - 014 UNVOP (University Hosp)	Reimbursement Classification	RC Outpatient Hosp
Methodology/Logic	Out of State Transplant/Related claims will price using the pricing method: PAPCTB (Pricing Method(s): This pricing method will look to see if the provider and member have a contracted rate on the provider contract rate panel for the date of service. If so, to determine the Medicaid allowed amount, the detail non-covered		

	<p>amount is subtracted from the detail billed amount and the remainder is multiplied by the applicable (based on date of service) Contract rate. Medicaid reimbursement is determined by subtracting the other insurance amount, if any.</p> <p>This pricing method applies to both inpatient and outpatient claims.</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.10.7 Claim Type O Home Care Waiver Services (Prov Type 46)

Alpha Claim Type	O (formerly Legacy U)	Provider Type	46
Provider Contract	HCARE	Reimbursement Classification	RC Home Care Waiver
Methodology/Logic	<p>Home Care Waiver claims will price using the pricing method:</p> <p>PPRUNL (Provider Priced)</p> <p>BILLED (Billed)</p> <p>Note: This provider type and its related services has been end dated as of 3/31/2003.</p> <p>Pricing Method(s):</p> <p>The PPRUNL pricing method will get the provider’s specific percentage rate using the (HW1), (HW2), (HW3) rate type for the date of service on the claim (detail). The provider’s specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p><u>Service 581 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (HW1).</p> <p><u>Service 582 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (HW2).</p> <p><u>Service 590 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of</p>		

	<p>(HW3).</p> <p><u>Service 290 (Revenue Code)</u></p> <p>This service will use the BILLED pricing method with a rate type of (NA).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>
Exceptions	There are no exceptions.

4.10.8 Claim Type O: Model Waiver 2 (Prov Type 41)

Alpha Claim Type	O (formerly Legacy U)	Provider Type	41
Provider Contract	MODWV	Reimbursement Classification	RC Model Waiver
Methodology/Logic	<p>Model Waiver 2 claims will price using the pricing method:</p> <p>PPRUNL (Provider Priced)</p> <p>Pricing Method(s):</p> <p>The PPRUNL pricing method will get the provider’s specific percentage rate using the (MW1), (MW2), (MW3) rate type for the date of service on the claim (detail). The provider’s specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p><u>Service 410 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (MW1).</p> <p><u>Service 552 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (MW2).</p> <p><u>Service 559 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (MW3).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p>		

	Additional Reimbursement Info: None
Exceptions	There are no exceptions.

4.10.9 Claim Type O: Personal Care Waiver Services (Prov Type 47)

Alpha Claim Type	O (formerly Legacy U)	Provider Type	47
Provider Contract	PRSNL	Reimbursement Classification	RC Personal Care Wvr
Methodology/Logic	<p>Personal Care Waiver claims will price using the pricing method:</p> <p>PPRUNL (Provider Priced)</p> <p>Note: This provider type and its related services has been end dated as of 3/31/2003.</p> <p>Pricing Method(s):</p> <p>The PPRUNL pricing method will get the provider's specific percentage rate using the (PW1), (PW2), (PW3) rate type for the date of service on the claim (detail). The provider's specific rate can be found on the Provider Rate panel for that provider. The rate is multiplied by the units. This value is compared to the billed amount. The reimbursement is the lesser of the billed amount or the calculated allowed amount (less patient liability and other insurance, if any).</p> <p><u>Service 581 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (PW1).</p> <p><u>Service 590 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (PW2).</p> <p><u>Service 942 (Revenue Code)</u></p> <p>This service will use the PPRUNL pricing method with a rate type of (PW3).</p> <p>Default Pricing Logic: None</p> <p>Pricing Method - Services which price from PA: None</p> <p>Additional Reimbursement Info: None</p>		
Exceptions	There are no exceptions.		

4.11 Claim Type P or Q

4.11.1 Pharmacy claims

Pharmacy claims will be price by the Pharmacy Benefits Manager (PBM).

5 Appendix A- Pricing Manual How To Guide

5.1 Viewing Provider Contract Rate Information

STEP 1. Access a Provider file.

The screenshot displays two main panels. The top panel, titled "Provider Information", contains fields for:

- Provider Identifier:** 100000009
- UPIN:** 456456
- Ownership:** No
- Restriction:** Yes
- Gender:** Organizatio
- Date of Birth:**
- SSN:**
- Service Location:** 100000099A - COUNTRY MEDICAL CLINIC
- Provider Numbers:** 2222222222 CMV 01/01/2001-12/31/2001
- Address Type:** Service Location
- Address:** 5585 MAIN ST
- City:** HARTFORD
- County:** Owsley
- State/Zip:** CT 06103
- Phone:** 999-551-3353
- Fax:**
- Managed Care:** No
- Organization:** Individual
- Provider Type:** 64 - Physician Individual
- License:**
- Specialties:** General Practitioner 01/01/1986-12/31/2299
- Taxonomies:** 203B00000X Uncategorized: General
- Tax ID:** 000000066 01/01/1986-12/31/2299
- Contract:** Presumptive Elig 01/01/1900-12/31/2299
- Medicare Certification:** Board

 The bottom panel, titled "Provider Maintenance", shows a grid of options to add or modify. The "Provider Contract Rate" option is highlighted in blue. Other options include Account Recoup Maximum, CLIA Maintenance, DEA, Disproportionate Share Rate, Group, Language, Owner, Payment Pull, Provider Lockin, Review, Supervising Physician, Taxonomy, Certification, Customary Charge, Disproportionate Share, Facility, IDs, Medicare Number, and Provider Assistant.

Provider Information and Maintenance Panels

STEP 2. Select "Provider Contract Rate" link from the Provider Maintenance panel by clicking on it one time.

This screenshot shows the "Provider Maintenance" panel with the "Service Location" sub-panel selected. The "Provider Contract Rate" option is highlighted in blue. Other options visible include Owner, Provider Beds, Provider Location Name Address, Restricted Service, State Share, Tax ID, Payment Pull, Provider Lockin, Review, Supervising Physician, Taxonomy, Physician Assistant, Provider DRG Rate, Provider Rate, Service Location, SURS Specialty, and Type and Specialty.

Provider Maintenance/Service Location Panel

The Provider Contract Rate panel will open.

STEP 3. Select a row to update by clicking on it one time. The information will populate into the fields of the panel.

The screenshot shows the "Provider Contract Rate" panel. At the top, there is a table with columns: Member ID, Member Name, Percent Contract Rate, Claim Type, First Date Service, and End Date Service. Two rows are visible:

Member ID	Member Name	Percent Contract Rate	Claim Type	First Date Service	End Date Service
999995771	TRAIN, VICKI	22.0%	1892 INST XOVER CLAIMS	05/01/2007	05/15/2007
991999259	TRAIN, MARY	20.0%	OUTPATIENT CLAIMS	06/05/2007	06/15/2007

 Below the table, the information for the selected row (9999912589) is populated into input fields:

- Member ID*:** 9999912589
- Member Name:** TRAIN, MARY
- Percent Contract Rate*:** 20.0%
- Claim Type*:** OUTPATIENT CLAIMS
- First Date Service*:** 06/05/2007
- End Date Service*:** 06/15/2007

 An "add" button is located at the bottom right of the panel.

5.1.1 Provider Contract Rate Panel Field Descriptions

Field	Description
Member ID	The Medicaid number of the Member to which this rate applies.
Member Name	Name of the Member.
Percent Contract Rate	The percentage amount for this claim that has been contracted by the Commonwealth with the provider of the services.
Claim Type	The type of claim this rate applies to, valid values are Inpatient and Outpatient.
First Date Service	The first date of service that this rate applies.
End Date Service	The last date of service that this rate applies.

5.1.2 Provider Contract Rate Panel Button Description

Field	Description
Add	Allows user to add a new contract rate.

5.2 Viewing a Provider's Out-of-State Organ Transplant Rate

A provider's out-of-state transplant rates are specific to the billing provider, the member and the dates of service.

STEP 1. Follow the instructions for **Viewing Provider Contract Rate Information**.

STEP 2. Select the applicable member and date of service.

The contract rate will display for the specified member and date of service.

The screenshot shows a software interface titled "Provider Contract Rate". At the top, there is a table with columns: Member ID, Member Name, Percent Contract Rate, Claim Type, First Date Service, and End Date Service. The table contains two rows of data:

Member ID	Member Name	Percent Contract Rate	Claim Type	First Date Service	End Date Service
9999995771	TRAJN, VICKI	22.0%	UB92 INST XOVER CLAIMS	05/01/2007	05/15/2007
9919992589	TRAJN, MARY	20.0%	OUTPATIENT CLAIMS	06/05/2007	06/15/2007

Below the table, there is a search form with the following fields:

- Member ID*: 99999912589 [Search]
- Member Name: TRAJN, MARY
- Percent Contract Rate*: 20.0%
- Claim Type*: OUTPATIENT CLAIMS (dropdown menu)
- First Date Service*: 06/05/2007
- End Date Service*: 06/15/2007

An "Add" button is located at the bottom right of the form area.

5.2.1 Provider Contract Rate Panel Field Descriptions

Field	Description
Member ID	The Medicaid number of the Member to which this rate applies.
Member Name	Name of the Member.

Percent Contract Rate	The percentage amount for this claim that has been contracted by the Commonwealth with the provider of the services.
Claim Type	The type of claim this rate applies to, valid values are Inpatient and Outpatient.
First Date Service	The first date of service that this rate applies.
End Date Service	The last date of service that this rate applies.

5.2.2 Provider Contract Rate Panel Button Description

Field	Description
Add	Allows user to add a new contract rate.

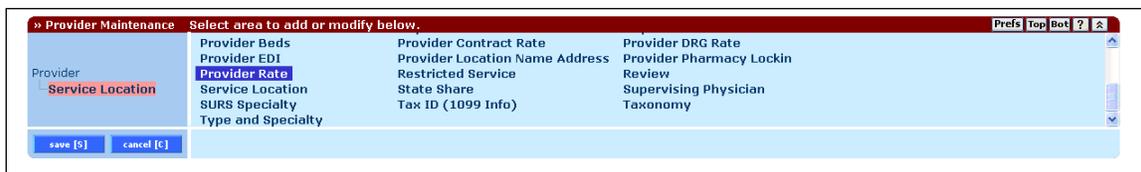
5.3 Viewing a Provider’s Flat Rate

STEP 1 Access a Provider file.



Provider Information and Maintenance Panels

STEP 2 Select the “Provider Rate” link from the Provider Maintenance panel by clicking on it one time.



Provider Maintenance/Service Location Panel

The Provider Rate panel will open.

STEP 3. To view the flat rate amount, click on the applicable row one time.

The information from the row will populate in the fields below.



5.3.1 Provider/ Provider Rate Panel Field Descriptions

Field	Description
Rate Type	Reimbursement rate type.
Flat Rate Amount	Provider's rate dollar amount.
Percentage Amount	Provider's percentage of charge amount.
Effective Date	Effective date of the rate.
End Date	End date of the rate.
Active Date	Date and time the rate segment is active.
Inactive Date	Date and time the rate segment is inactive.

5.3.2 Provider/Provider Rate Panel Button Description

Field	Description
Add	Allows user to add a new flat rate.

5.3.3 Viewing a Provider’s Flat Rate for Rate Type PED

STEP 1. Follow the instructions for **Viewing a Provider’s Flat Rate**.

STEP 2. Select the row the displays rate type PED.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.4 Viewing a Provider’s Flat Rate for Rate Type DEF

STEP 1. Follow the instructions for **Viewing a Provider’s Flat Rate**.

STEP 2. Select the row the displays rate type DEF.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.5 Viewing a Provider's Flat Rate for Rate Type HC1

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC1.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.6 Viewing a Provider's Flat Rate for Rate Type HC2

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC2.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.7 Viewing a Provider's Flat Rate for Rate Type HC3

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC3.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.8 Viewing a Provider's Flat Rate for Rate Type HC4

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC4.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.9 Viewing a Provider's Flat Rate for Rate Type HC5

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC5.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.10 Viewing a Provider's Flat Rate for Rate Type HC6

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC6.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.11 Viewing a Provider's Flat Rate for Rate Type HC7

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC7.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.12 Viewing a Provider's Flat Rate for Rate Type HC8

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HC8.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.13 Viewing a Provider's Flat Rate for Rate Type HH1

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH1.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.14 Viewing a Provider's Flat Rate for Rate Type HH2

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH2.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.15 Viewing a Provider's Flat Rate for Rate Type HH3

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH3.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.16 Viewing a Provider's Flat Rate for Rate Type HH4

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH4.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.17 Viewing a Provider's Flat Rate for Rate Type HH5

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH5.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.18 Viewing a Provider's Flat Rate for Rate Type HH6

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH6.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.19 **Viewing a Provider's Flat Rate for Rate Type HH7**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH7.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.20 **Viewing a Provider's Flat Rate for Rate Type HH8**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HH8.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.21 **Viewing a Provider's Flat Rate for Rate Type HW1**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type PHW1.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.22 **Viewing a Provider's Flat Rate for Rate Type HW2**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HW2.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.23 **Viewing a Provider's Flat Rate for Rate Type HW3**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type HW3.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.24 **Viewing a Provider's Flat Rate for Rate Type MR1**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type MR1.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.25 **Viewing a Provider's Flat Rate for Rate Type MW1**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type MW1

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.26 **Viewing a Provider's Flat Rate for Rate Type MW2**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type MW2.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.27 **Viewing a Provider's Flat Rate for Rate Type MW3**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type PMW3.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.28 **Viewing a Provider's Flat Rate for Rate Type NF41**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type NF41.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.29 **Viewing a Provider's Flat Rate for Rate Type PCC**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type PCC.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.30 **Viewing a Provider's Flat Rate for Rate Type PW1**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type PW1.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.31 **Viewing a Provider's Flat Rate for Rate Type PW2**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type PW2.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.32 **Viewing a Provider's Flat Rate for Rate Type PW3**

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type PW3.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.33 Viewing a Provider's Flat Rate for Rate Type RH1

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type RH1.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.34 Viewing a Provider's Flat Rate for Rate Type RD1

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type RD1.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.35 Viewing a Provider's Flat Rate for Rate Type RD3

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type RD3.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.36 Viewing a Provider's Flat Rate for Rate Type RD4

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type RD4.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.3.37 Viewing a Provider's Flat Rate for Rate Type RD5

STEP 1. Follow the instructions for **Viewing a Provider's Flat Rate**.

STEP 2. Select the row the displays rate type RD5.

The information from the row will populate in the fields of the panel, displaying the flat rate amount for the rate type.

5.4 Viewing a Provider's Specific Percentage Rate

STEP 1 Access a Provider file.

Provider Information

Provider Identifier: 100000009
 UPIN: 456456
 Ownership: No
 Restriction: Yes
 Gender: Organization
 Date of Birth: [blank]
 SSN: [blank]

Service Location: 10000009A - COUNTRY MEDICAL CLINIC
 Provider Numbers: 2222222222 CMV 01/01/2001-12/31/2001
 Address Type: Service Location
 Address: 5585 MAIN ST
 City: HARTFORD
 County: Owsley
 State/Zip: CT 06103
 Phone: 999-551-3353
 Fax: [blank]
 Managed Care: No

Organization: Individual
 Provider Type: 64 - Physician Individual
 License: [blank]
 Specialties: General Practitioner 01/01/1986-12/31/2299
 Taxonomies: 203BG0000X Uncategorized: General
 Tax ID: 000000066 01/01/1986-12/31/2299
 Contract: Presumptive Elig 01/01/1900-12/31/2299
 Medicare Certification Board: [blank]

Provider Maintenance Select area to add or modify below.

Account Recoup Maximum	Board Participant	Certification
CLIA Maintenance	Contract	Customary Charge
DEA	Dispensing Fee	Disproportionate Share
Disproportionate Share Rate	EFT Account	Facility
Group	Group Member	IDs
Language	License	Medicare Number
Contract	Request Refill	Provider Assistant

Provider Information and Maintenance Panels

STEP 2 Select the “Provider Rate” link from the Provider Maintenance panel by clicking on it one time.

Provider Maintenance Select area to add or modify below.

Provider Beds	Provider Contract Rate	Provider DRG Rate
Provider EDI	Provider Location Name Address	Provider Pharmacy Lockin
Provider Rate	Restricted Service	Review
Service Location	State Share	Supervising Physician
SURS Specialty	Tax ID (1099 Info)	Taxonomy
Type and Specialty		

Provider Maintenance/Service Location Panel

The Provider Rate panel will open.

STEP 3. To view the percentage rate, click on the applicable row one time.

The information from the row will populate in the fields of the panel.

Provider Rate

Rate Type	Flat Rate Amount	Percentage Amount	Active Date	Inactive Date	Effective Date	End Date
Rates Audit Trails	\$22.00	0%	06/19/2006	06/22/2299	06/19/2006	06/22/2299
Rates Audit Trails	\$12.00	0%	06/12/2006	06/12/2006	01/01/1900	12/31/2299
MH Private	\$24.00	0%	06/12/2006	06/14/2006	01/01/1900	12/31/2299
MH Private	\$23.00	0%	06/15/2006	12/31/2299	01/01/1900	12/31/2299

Type changes below.

Rate Type*: MH Private
 Flat Rate Amount: \$24.00
 Percentage Amount: 0%
 Active Date*: 06/12/2006
 Inactive Date*: 06/14/2006
 Effective Date*: 01/01/1900
 End Date*: 12/31/2299

add

5.4.1 Provider/ Provider Rate Panel Field Descriptions

Field	Description

Rate Type	Reimbursement rate type.
Flat Rate Amount	Provider's rate dollar amount.
Percentage Amount	Provider's percentage of charge amount.
Effective Date	Effective date of the rate.
End Date	End date of the rate.
Active Date	Date and time the rate segment is active.
Inactive Date	Date and time the rate segment is inactive.

5.4.2 Provider/Provider Rate Panel Button Description

Field	Description
Add	Allows user to add a new percentage rate.

5.4.3 Viewing the Provider Percentage Rate for Rate Type ASD

STEP 1. Follow the instructions for **Viewing a Provider's Specific Percentage Rate**.

STEP 2. Select the row the displays rate type ASD.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.4.4 Viewing the Provider Percentage Rate for Rate Type CHC

STEP 1. Follow the instructions for **Viewing a Provider's Specific Percentage Rate**.

STEP 2. Select the row the displays rate type CHC.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.4.5 Viewing the Provider Percentage Rate for Rate Type MR2

STEP 1. Follow the instructions for **Viewing a Provider's Specific Percentage Rate**.

STEP 2. Select the row the displays rate type MR2.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.4.6 Viewing the Provider Percentage Rate for Rate Type NF2

STEP 1. Follow the instructions for **Viewing a Provider's Specific Percentage Rate**.

STEP 2. Select the row the displays rate type NF2.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.4.7 Viewing the Provider Percentage Rate for Rate Type OP1

STEP 1. Follow the instructions for **Viewing a Provider’s Specific Percentage Rate**.

STEP 2. Select the row the displays rate type OP1.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.4.8 Viewing the Provider Percentage Rate for Rate Type OP2

STEP 1. Follow the instructions for **Viewing a Provider’s Specific Percentage Rate**.

STEP 2. Select the row the displays rate type OP2.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.4.9 Viewing the Provider Percentage Rate for Rate Type RD2

STEP 1. Follow the instructions for **Viewing a Provider’s Specific Percentage Rate**.

STEP 2. Select the row the displays rate type RD2.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.4.10 Viewing the Provider Percentage Rate for Rate Type RH2

STEP 1. Follow the instructions for **Viewing a Provider’s Specific Percentage Rate**.

STEP 2. Select the row the displays rate type RH2.

The information from the row will populate in the fields below, displaying the percentage rate for that rate type.

5.5 Viewing a Provider’s Per Diem Rate

STEP 1 Access a Provider file.

Provider Information			
Provider Identifier	100000009	Service Location	100000099A - COUNTRY MEDICAL CLINIC
UPIN	456456	Provider Numbers	222222222222 CMV 01/01/2001-12/31/2001
Ownership	No	Address Type	Service Location
Restriction	Yes	Address	5585 MAIN ST
Gender	Organizatio	City	HARTFORD
Date of Birth		County	Owsley
SSN		State/Zip	CT 06103
		Phone	999-551-3353
		Fax	
		Managed Care	No
Organization	Individual	Provider Type	64 - Physician Individual
License		Specialties	General Practitioner01/01/1986-12/31/2299
Taxonomies	203BC0000X	Tax ID	000000066 01/01/1986-12/31/2299
Contract	Presumptive Elig	Medicare	01/01/1900-12/31/2299
Certification		Board	

Provider Maintenance			
Select area to add or modify below.			
Provider	Account Recoup Maximum	Board Participant	Certification
Service Location	CLIA Maintenance	Contract	Customary Charge
	DEA	Dispensing Fee	Disproportionate Share
	Disproportionate Share Rate	EFT Account	Facility
	Group	Group Member	IDS
	Language	License	Medicare Number
	Group	Present Bill	Provider Assistant

Provider Information and Maintenance Panels

STEP 2 Select the “Provider Rate” link from the Provider Maintenance panel by clicking on it one time.



Provider Maintenance/Service Location Panel

The Provider Rate panel will open.

STEP 3. To view the per diem rate, click on the applicable row one time.

The information from the row will populate in the fields of the panel.



5.5.1 Provider/ Provider Rate Panel Field Descriptions

Field	Description
Rate Type	Reimbursement rate type.
Flat Rate Amount	Provider's rate dollar amount.
Percentage Amount	Provider's percentage of charge amount.
Effective Date	Effective date of the rate.
End Date	End date of the rate.
Active Date	Date and time the rate segment is active.
Inactive Date	Date and time the rate segment is inactive.

5.5.2 Provider/Provider Rate Panel Button Description

Field	Description
Add	Allows user to add a new per diem rate.

5.5.3 Viewing a Provider's Per Diem Rate for Rate Type DSH

STEP 1. Follow the instructions for **Viewing a Provider's Per Diem Rate**.

STEP 2. Select the row that displays rate type DSH.

The information from the row will populate in the fields below, displaying the per diem rate for that rate type.

5.5.4 Viewing a Provider's Per Diem Rate for Rate Type DS1

STEP 1. Follow the instructions for **Viewing a Provider's Per Diem Rate**.

STEP 2. Select the row that displays rate type DS1.

The information from the row will populate in the fields below, displaying the per diem rate for that rate type.

5.5.5 Viewing a Provider's Per Diem Rate for Rate Type DS2

STEP 1. Follow the instructions for **Viewing a Provider's Per Diem Rate**.

STEP 2. Select the row that displays rate type DS2.

The information from the row will populate in the fields below, displaying the per diem rate for that rate type.

5.5.6 Viewing a Provider's Per Diem Rate for Rate Type IPI

STEP 1. Follow the instructions for **Viewing a Provider's Per Diem Rate**.

STEP 2. Select the row that displays rate type IPI.

The information from the row will populate in the fields below, displaying the per diem rate for that rate type.

5.5.7 Viewing a Provider's Per Diem Add On Rate

STEP 1. Follow the instructions for **Viewing a Provider's Per Diem Rate**.

STEP 2. Select the row that displays rate type ADD.

The information from the row will populate in the fields below, displaying the per diem add on rate for that rate type.

5.6 Viewing a Provider's Specific DRG Rates

STEP 1. Access a provider file.

Provider Information and Maintenance Panels

STEP 2. Select “Provider DRG Rate” from the Provider Maintenance panel by clicking on the link one time.

The Provider DRG Rate Panel will open.

Provider DRG Rate Panel

5.6.1 Provider DRG Rate Panel Field Descriptions

Field	Description
DRG	The code for this diagnosis related grouping.
Effective Date	The date a rate becomes effective within a DRG for the current Provider ID.
Description	The description for the DRG.

End Date	The last date for the current rate within a DRG for the current Provider ID.
Operating Base Rate	The provider's operating base rate. Format 99999999.99.
Cost Charge Rate	Percentage to be charged. Format 999.99.
Rate Type	Reimbursement rate type.
Capital Cost Rate	The provider's capital cost rate.
Capital IME Factor	The provider's capital IM factor/percentage. Format 999.99
Hi Intensity add-on	The provider's hi intensity add-on rate. Format 9999.99
Operating IME Factor	The provider's operating IME factor/percentage. Format 999.99
Cost Outlier Number	This is the outlier threshold. This cost is used in outlier payment determination.
Cost Outlier Percentage	Marginal Cost Percentage used to calculate price for cost outlier pricing. (Percent Cost)
Inactive Date	Date the segment becomes inactive.

5.6.2 Provider/DRG Rate Panel Button Descriptions

Button	Description
Delete	Delete a DRG Rate
Add	Add a DRG Rate.

5.6.3 Viewing a Provider's DRG Rate for Rate Type DEF

STEP 1. Follow the instructions for Viewing a **Provider's Specific DRG Rates**

STEP 2. Select the row that displays rate type **DEF**.

The information from the row will display onto the fields of the panel.

5.6.4 Viewing a Provider's DRG Rate for Rate Type DRG

STEP 1. Follow the instructions for Viewing a **Provider's Specific DRG Rates**

STEP 2. Select the row that displays rate type **DRG**.

The information from the row will display onto the fields of the panel.

5.6.5 Viewing a Provider's DRG Rate for Rate Type DRP

STEP 1. Follow the instructions for Viewing a **Provider's Specific DRG Rates**

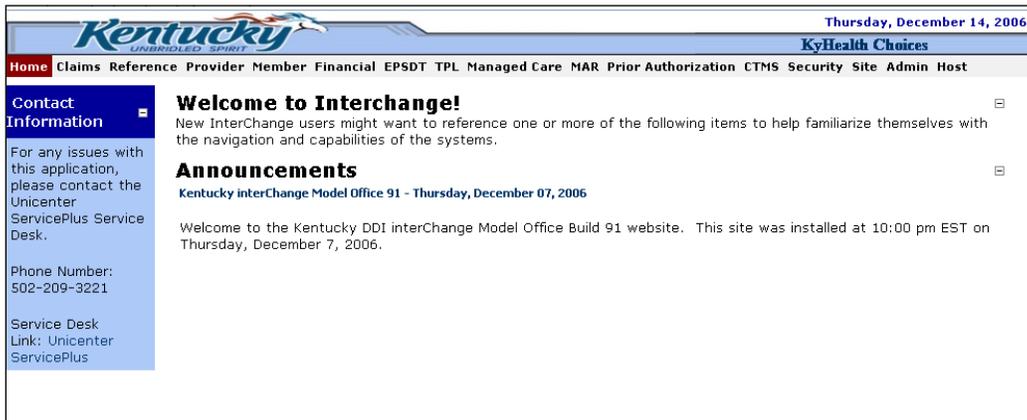
STEP 2. Select the row that displays rate type **DRP**.

The information from the row will display onto the fields of the panel.

5.7 Viewing DRG Rates

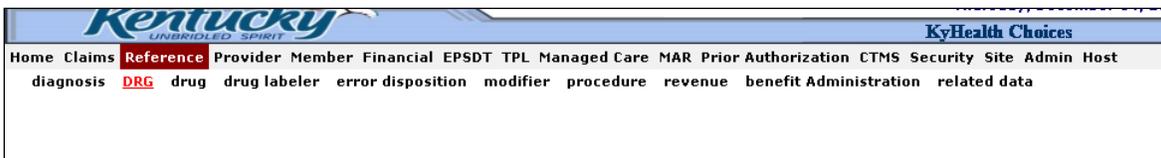
STEP 1. Access interChange.

STEP 2. Select Reference from the main menu.

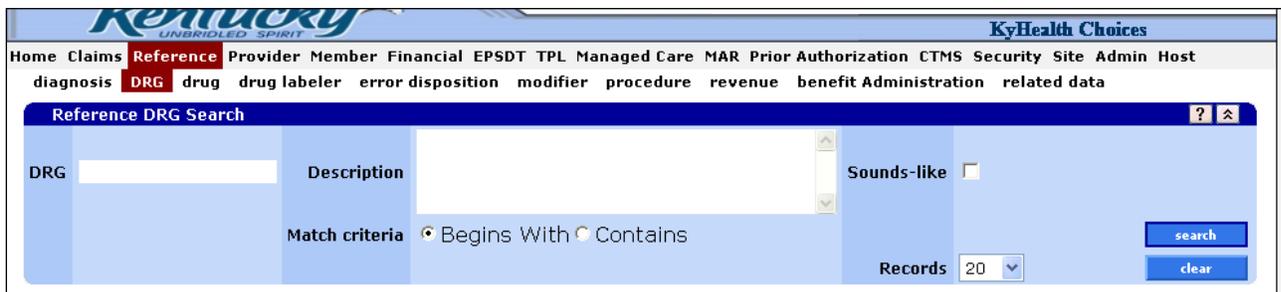


InterChange Home Page

STEP 3. Select DRG from the Reference menu.



The DRG Search panel will open.



DRG Search Panel

5.7.1 Reference / DRG Search Pan DRG Search Panel Field Descriptions

Field	Description
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DRG	This field is used to identify a unique code to tag a specific Diagnosis Related Group (DRG). They classify hospital cases into one of approximately 500 groups, also referred to as DRGs. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or co-morbidities.
Description	This field is used to describe a unique code to tag a specific Diagnosis Related Group (DRG).
Match criteria	Allows the user to specify criteria for matching based on "begins with" or "contains."
Sounds-like	Allows the user to perform a phonetic search on description. If the box is checked, a phonetic search is performed using the input description. If the box is not checked a literal search is performed.
Records	Allows the user to specify the number of rows returned from the search.

5.7.2 DRG Search Panel Button Descriptions

Button	Description
Search	Initiates search on the database table for records matching the criteria entered.

STEP 4. Enter the DRG code in the DRG field. Click on the "Search" button.

The screenshot displays the 'Reference DRG Search' interface. At the top, there is a navigation bar with 'KyHealth Choices' and various menu items like 'Home', 'Claims', 'Reference', 'Provider', etc. Below this, a breadcrumb trail shows 'diagnosis > DRG > drug > drug labeler > error disposition > modifier > procedure > revenue > benefit Administration > related data'. The main search area has a title 'Reference DRG Search' and a search icon. The form includes:

- A 'DRG' input field containing '0091'.
- A 'Description' text area.
- 'Match criteria' radio buttons: 'Begins With' (selected) and 'Contains'.
- A 'Sounds-like' checkbox, which is currently unchecked.
- A 'Records' dropdown menu set to '20'.
- 'search' and 'clear' buttons.

STEP 5. The following panels will open: DRG Information and DRG Maintenance.



DRG Information and Maintenance Panels

STEP 6. Select the “Rates” link from the DRG Maintenance panel by clicking on it one time.



DRG Maintenance Panel

The Rates panel will open.

STEP 7. Select a row by clicking on it one time. The information will populate into the fields of the panel.



Rates Panel

5.7.3 Reference/DRG/Rates Panel Field Descriptions

Field	Description
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Rate Type	Identifies the type of rate for the chosen Diagnosis Related Group (DRG) code.
Weight	This is an assigned DRG weight that reflects the relative resource used to treat the diagnosis. Format 999.9999.
GEO Length of Stay	Kentucky Geometric Length of Stay. Format is 9999.9.
Length of Stay	Number of length of stay in days. Format 9999.9.
PAC Ind	Indicates if the DRG is post acute. Values are Yes and No.
SP. Rule Ind	Indicates if the DRG is special rule. Values are Yes and No.
Effective Date	The date a rate becomes effective within a DRG.
End Date	The last date for a rate within a DRG.
Inactive Date	Rate segment inactive date. This is the date that the rate can no longer be used, regardless of the dates of service on the claim.

5.7.4 Reference/DRG/Rates Panel Button Descriptions

Button	Description
Add	Add a DRG rate.

5.7.5 Viewing a DRG Rate for Rate Type DEF

STEP 1. Follow the instructions for **Viewing Rates for a Specific DRG**

STEP 2. Select the row that displays Rate Type **DEF**.

The information from the row will display in the fields on the panel.

5.7.6 Viewing a DRG Rate for Rate Type DRG

STEP 1. Follow the instructions for **Viewing Rates for a Specific DRG**

STEP 2. Select the row that displays Rate Type **DRG**.

The information from the row will display in the fields on the panel.

5.7.7 Viewing a DRG Rate for Rate Type DRP

STEP 1. Follow the instructions for **Viewing Rates for a Specific DRG**

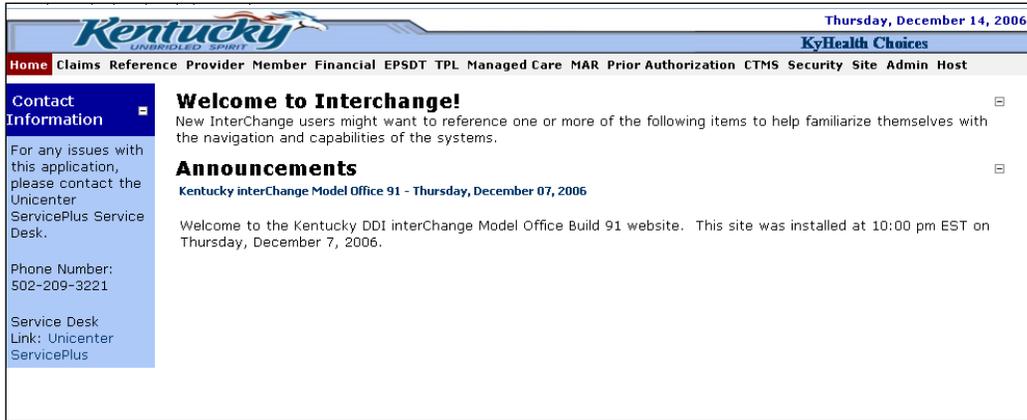
STEP 2. Select the row that displays Rate Type **DRP**.

The information from the row will display in the fields on the panel.

5.8 Viewing a Procedure Max Fee Rate

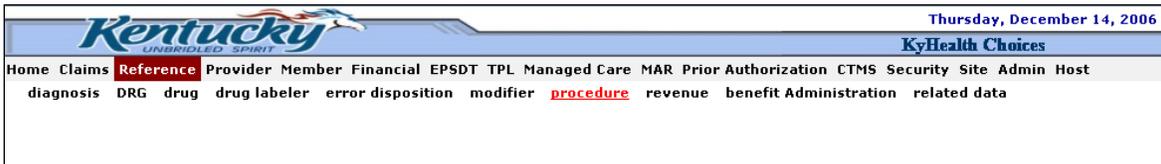
STEP 1. Access interChange.

STEP 2. Select Reference from the main menu.

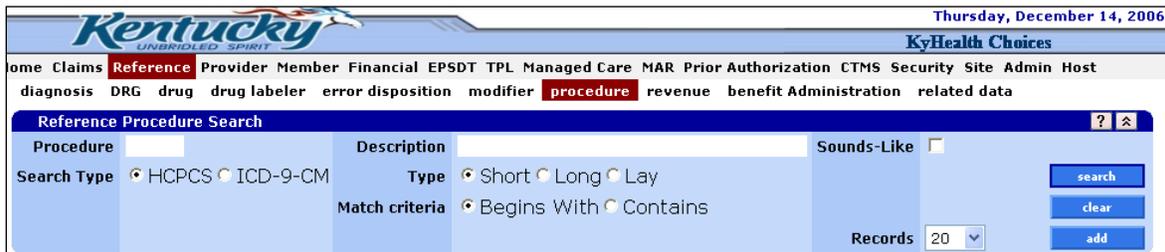


InterChange Home Page

STEP 3. Select Procedure from the Reference menu.



The Reference Procedure Search panel will open.



Reference / Procedure Search Panel

5.8.1 Procedure Search Panel Field Descriptions

Field	Description
Procedure	A code used to identify a procedure code, used as search criteria in the search.
Search Type	Allows the user to search either a HCPCS or ICD-9-CM procedure code.
Description	Short text that describes the procedure, used as search criteria in the search.
Type	Allows searching on the short description, long description or lay description.
Match criteria	Allows the user to specify criteria for matching based on “begins with” or “contains.”
Sounds-like	Allows the user to perform a phonetic search on description. If the box is checked, a phonetic search is performed using the input description. If the box is not checked a literal search is performed.
Records	Allows the user to specify the number of rows returned from the search.

5.8.2 Procedure Search Panel Button Descriptions

Button	Description
Search	Initiates search on the database table for records matching the criteria entered.
Clear	Clears the criteria fields so user may enter new criteria.
Add	Opens all necessary panels to allow the user to enter data and create a new Procedure code in Interchange.

STEP 4. Enter the HCPCS procedure code in the Procedure field. In the Search Type field, select “HCPCS”. Click on the “Search” button.

The screenshot displays the 'Reference Procedure Search' interface. At the top, there is a navigation menu with 'Reference' highlighted. Below the menu, there is a search form with the following fields and options:

- Procedure:** 99212
- Description:** (empty text box)
- Search Type:** Radio buttons for HCPCS (selected) and ICD-9-CM.
- Type:** Radio buttons for Short (selected), Long, and Lay.
- Match criteria:** Radio buttons for Begins With (selected) and Contains.
- Sounds-Like:** A checkbox that is currently unchecked.
- Records:** A dropdown menu set to 20.

At the bottom right of the form, there are three buttons: 'search', 'clear', and 'add'.

The following panels will open: HCPCS Procedure Information and Maintenance Panels



HCPCS Procedure Information and Maintenance Panels

STEP 5. Select the “Max Fee” link from the Procedure Maintenance panel by clicking on it one time.



Procedure Maintenance Panel

The Max Fee panel will open.

STEP 6. Select a row by clicking on it one time. The information will populate into the fields of the panel.

The screenshot shows a software interface titled "Max Fee". At the top, there is a table with columns: Modifier, Modifier2, Modifier3, Modifier4, Rate Type, Allowed Amount, Relative Value, Effective Date, End Date, and Inactive Date. The table lists several entries with their respective values and dates. Below the table, there is a form for adding a new record. The form fields include: Modifier (AM), Modifier2 (UI), Modifier3, Modifier4, Rate Type* (FP1 - Family Planning 1), Allowed Amount* (\$25.00), Relative Value* (0.0), Effective Date* (12/16/2003), End Date* (12/31/2299), and Inactive Date* (12/31/2299). There are "delete" and "add" buttons at the bottom right of the form.

Max Fee Panel

5.8.3 Reference/Procedure/HCPCS/Procedure/Max Fee Panel Field Descriptions

Field	Description
Modifier	Modifier used to further describe procedure code. User can use the 'search' link to select a modifier.
Modifier 2	Second modifier used to further describe procedure code. User can use the 'search' link to select a modifier.
Modifier 3	Third modifier used to further describe procedure code. User can use the 'search' link to select a modifier.
Modifier 4	Fourth modifier used to further describe procedure code. User can use the 'search' link to select a modifier.
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.
Allowed Amount	The maximum amount that may be paid for the Procedure Code. Format 9999999.99.
Relative Value	The relative value unit is a grading of the relative difficulty of medical services and procedures used in determining payment. Format 999.9.
Effective Date	Based on date of service, this is the date the procedure code or procedure code/modifier combination becomes effective for claims processing.
End Date	Based on date of service, this is the last day the procedure code or procedure code/modifier combination is effective for use in claims processing.

Inactive Date	Date/time the max fee can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future inactive date restrictions prevent inactivating a segment while claims are processing.
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5.8.4 Reference/Procedure/HCPCS/Procedure/Max Fee Panel Button Descriptions

Button	Description
Add	Allows user to add a new max fee for this procedure.
Delete	Allows user to delete a max fee record from this procedure.

5.8.5 Viewing a Max Fee for Rate Type DEF

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type DEF**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.6 Viewing a Max Fee for Rate Type EP1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type EP1**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.7 Viewing a Max Fee for Rate Type FP1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type FP1**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.8 Viewing a Max Fee for Rate Type MX1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type MX1**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.9 Viewing a Max Fee for Rate Type MX2

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type MX2**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.10 Viewing a Max Fee for Rate Type N1A

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N1A**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.11 Viewing a Max Fee for Rate Type N1B

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N1B**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.12 Viewing a Max Fee for Rate Type N2A

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N2A**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.13 Viewing a Max Fee for Rate Type N2B

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N2B**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.14 Viewing a Max Fee for Rate Type N2C

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N2C**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.15 Viewing a Max Fee for Rate Type N2D

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N2D**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.16 Viewing a Max Fee for Rate Type N2E

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N2E**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.17 Viewing a Max Fee for Rate Type N2F

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N2F**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.18 Viewing a Max Fee for Rate Type N2G

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N2G**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.19 Viewing a Max Fee for Rate Type N7A

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N7A**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.20 Viewing a Max Fee for Rate Type N7B

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N7B**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.21 Viewing a Max Fee for Rate Type N8A

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N8A**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.22 Viewing a Max Fee for Rate Type N8B

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N8B**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.23 Viewing a Max Fee for Rate Type N8B

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type N8B**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.24 Viewing a Max Fee for Rate Type NFD

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type NFD**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.25 Viewing a Max Fee for Rate Type NT2

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type NT2**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.26 Viewing a Max Fee for Rate Type OP1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type OP1**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.27 Viewing a Max Fee for Rate Type OP2

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type OP2**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.28 Viewing a Max Fee for Rate Type OT1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type OT1**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.29 Viewing a Max Fee for Rate Type P30

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type P30**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.30 Viewing a Max Fee for Rate Type P4I

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type P4I**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.31 Viewing a Max Fee for Rate Type P4O

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type P4O**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.32 Viewing a Max Fee for Rate Type P5O

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type P5O**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.33 Viewing a Max Fee for Rate Type P6O

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type P6O**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.34 Viewing a Max Fee for Rate Type P8O

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type P8O**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.35 Viewing a Max Fee for Rate Type PH1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type PHI**
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.36 Viewing a Max Fee for Rate Type PH2

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type PH2**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.37 Viewing a Max Fee for Rate Type PH3

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type PH3**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.38 Viewing a Max Fee for Rate Type PSI

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type PSI**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.39 Viewing a Max Fee for Rate Type PSO

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type PSO**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.40 Viewing a Max Fee for Rate Type RD1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type RD1**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.41 Viewing a Max Fee for Rate Type RD3

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type RD3**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.42 Viewing a Max Fee for Rate Type RD5

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type RD5**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.43 Viewing a Max Fee for Rate Type SBS

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type SBS**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.44 Viewing a Max Fee for Rate Type TR1

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type TR1**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.45 Viewing a Max Fee for Rate Type TR2

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type TR2**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.46 Viewing a Max Fee for Rate Type TR3

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type TR3**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.8.47 Viewing a Max Fee for Rate Type TR4

- STEP 1. Follow the instructions for **Viewing a Max Fee Rate**
- STEP 2. Select the row that displays **Rate Type TR4**.
- STEP 3. The information from the row will populate into the fields of the panel.

5.9 Viewing a Usual Customary Charge (UCC) Rate

- STEP 1 Access a Provider file.

Provider Information and Maintenance Panels

STEP 2 Select the “Customary Charge” link from the Provider Maintenance panel by clicking on it one time.

Provider Maintenance/Service Location Panel

The Customary Charge panel will open.

STEP 3. Select a row by clicking on it one time.

The information from the row will populate in the fields of the panel.

Procedure	Modifier 1	Modifier 2	Modifier 3	Modifier 4	UCC Rate	Rate Type	Effective Date	End Date	Inactive Date
0003T	1	56	62	22	\$3,242.00	Early Intervention	01/01/1900	12/31/2299	03/03/2008
0003T	21	22	1	24	\$234.00	Assistant Surgery	01/01/1900	12/31/2299	02/02/2009
0004F	25	1	26	24	\$34.00	MH Pub Child	01/01/1900	12/31/2299	02/02/2009
0005F	26	24	25	26	\$2,345.00	Default	01/01/1900	12/31/2299	02/02/2007
0005T	21	22	23	26	\$0.00	Default	01/01/1900	12/31/2299	02/02/2009
0005T	21	22	23	24	\$2,341.00	Dummy rate type	01/01/1900	12/31/2299	03/03/2005

5.9.1 Provider/Customary Charge Panel Field Descriptions

Field	Description
Procedure	Procedure Code
Modifier 1	Modifier used to further describe procedure code.
Modifier 2	Second modifier used to further describe procedure code.
Modifier 3	Third modifier used to further describe procedure code.
Modifier 4	Fourth modifier used to further describe procedure code.
Effective Date	Based on date of service, this is the date the procedure code or procedure code/modifier combination becomes effective for claims processing.
End Date	Based on date of service, this is the last day the procedure code or procedure code/modifier combination is effective for use in claims processing.
Inactive Date	Date/time the UCC rate can no longer be used regardless of dates of service on the claim.
UCC Rate	Usual and customary rate.
Rate Type	Identifies the rate type defined in the Reference reimbursement rules and used to determine provider payment.

5.9.2 Provider/Customary Charge Panel Button Descriptions

Button	Description
Add	Allows user to add a new UCC rate for this procedure.

5.9.3 Viewing a UCC Rate for Rate Type AD1

STEP 1. Follow the instructions for **Viewing a Usual Customary Charge (UCC) Rate**.

STEP 2. Select the row that displays rate type AD1.

The information from the row will populate in the fields of the panel.

5.9.4 Viewing a UCC Rate for Rate Type CM1

STEP 1. Follow the instructions for **Viewing a Usual Customary Charge (UCC) Rate**.

STEP 2. Select the row that displays rate type CM1.

The information from the row will populate in the fields of the panel.

5.9.5 Viewing a UCC Rate for Rate Type CM2

STEP 1. Follow the instructions for **Viewing a Usual Customary Charge (UCC) Rate**.

STEP 2. Select the row that displays rate type CM2.

The information from the row will populate in the fields of the panel.

5.9.6 Viewing a UCC Rate for Rate Type CM3

STEP 1. Follow the instructions for **Viewing a Usual Customary Charge (UCC) Rate**.

STEP 2. Select the row that displays rate type CM3.

The information from the row will populate in the fields of the panel.

5.9.7 Viewing a UCC Rate for Rate Type SC1

STEP 1. Follow the instructions for **Viewing a Usual Customary Charge (UCC) Rate**.

STEP 2. Select the row that displays rate type SC1.

The information from the row will populate in the fields of the panel.

5.9.8 Viewing a UCC Rate for Rate Type SC2

STEP 1. Follow the instructions for **Viewing a Usual Customary Charge (UCC) Rate**.

STEP 2. Select the row that displays rate type SC2.

The information from the row will populate in the fields of the panel.

5.9.9 Viewing a UCC Rate for Rate Type SC3

STEP 1. Follow the instructions for **Viewing a Usual Customary Charge (UCC) Rate**.

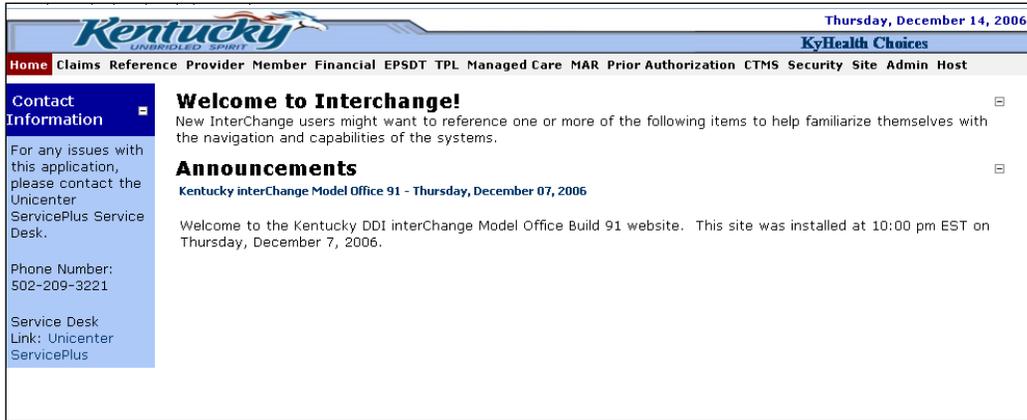
STEP 2. Select the row that displays rate type SC3.

The information from the row will populate in the fields of the panel.

5.10 Viewing an ASC Payment Group

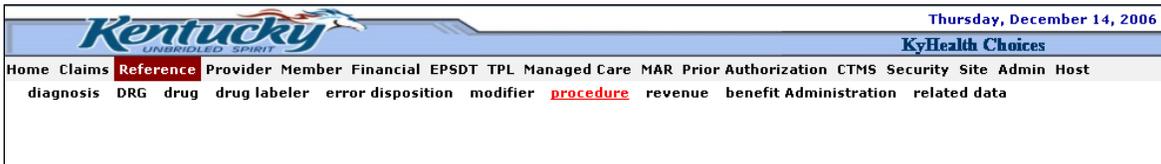
STEP 1. Access interChange.

STEP 2. Select Reference from the main menu.



InterChange Home Page

STEP 3. Select Procedure from the Reference menu.



The Reference Procedure Search panel will open.



Reference / Procedure Search Panel

5.10.1 Procedure Search Panel Field Descriptions

Field	Description
Procedure	A code used to identify a procedure code, used as search criteria in the search.
Search Type	Allows the user to search either a HCPCS or ICD-9-CM procedure code.
Description	Short text that describes the procedure, used as search criteria in the search.
Type	Allows searching on the short description, long description or lay description.
Match criteria	Allows the user to specify criteria for matching based on “begins with” or “contains.”
Sounds-like	Allows the user to perform a phonetic search on description. If the box is checked, a phonetic search is performed using the input description. If the box is not checked a literal search is performed.
Records	Allows the user to specify the number of rows returned from the search.

5.10.2 Procedure Search Panel Button Descriptions

Button	Description
Search	Initiates search on the database table for records matching the criteria entered.
Clear	Clears the criteria fields so user may enter new criteria.
Add	Opens all necessary panels to allow the user to enter data and create a new Procedure code in Interchange.

STEP 4. Enter the HCPCS procedure code in the Procedure field. In the Search Type field, select “HCPCS”. Click on the “Search” button.

The screenshot displays the 'Reference Procedure Search' interface. At the top, there is a navigation bar with 'Kentucky UNBRIDLED SPIRIT' and 'KyHealth Choices'. Below this is a menu of options: Home, Claims, Reference, Provider, Member, Financial, EPSDT, TPL, Managed Care, MAR, Prior Authorization, CTMS, Security, Site, Admin, Host. The 'Reference' option is highlighted. Underneath, a secondary menu lists: diagnosis, DRG, drug, drug labeler, error disposition, modifier, procedure, revenue, benefit Administration, related data. The 'procedure' option is highlighted. The main search area has a blue header 'Reference Procedure Search' with a help icon and a search icon. The form contains:

- Procedure:** 99212
- Description:** [Empty text box]
- Sounds-Like:**
- Search Type:** HCPCS ICD-9-CM
- Type:** Short Long Lay
- Match criteria:** Begins With Contains
- Records:** 20 (dropdown menu)

 On the right side, there are three buttons: 'search', 'clear', and 'add'.

The following panels will open: HCPCS Procedure Information and Maintenance Panels

HCPCS Procedure Information and Maintenance Panels

STEP 5. Select the “ASC Payment Group” link from the Procedure Maintenance panel by clicking on it one time.

Procedure Maintenance Panel

The ASC Payment Group panel will open.

STEP 6. Select a row by clicking on it one time. The information will populate into the fields of the panel.

ASC Payment Panel

5.10.3 Reference/Procedure/HCPCS/Procedure/ASC Payment Group Panel Field Descriptions

Field	Description
ASC Payment Group	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.
Effective Date	The date an ASC rate becomes effective for claims processing.
End Date	The date an ASC rate is no longer in effect for claims processing.

5.10.4 Reference/Procedure/HCPCS/Procedure/ASC Payment Group Panel Button Descriptions

Button	Description
Add	Add an ASC pricing segment.
Delete	Delete an ASC pricing segment.

5.10.5 Viewing the ASC Payment Group for Rate Type DEF

STEP 1. Follow the instruction for **Viewing an ASC Payment Group**.

STEP 2. Select the row that displays rate Type DEF.

The information from the row will populate in the fields on the panel.

5.10.6 Viewing the ASC Payment Group for Rate Type OPA

STEP 1. Follow the instruction for **Viewing an ASC Payment Group**.

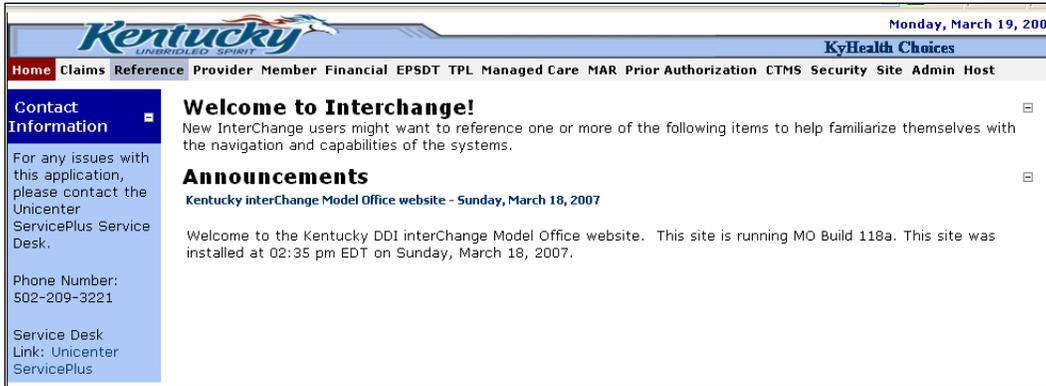
STEP 2. Select the row that displays rate Type OPA.

The information from the row will populate in the fields on the panel.

5.11 Viewing ASC Procedure Reimbursement Rates

STEP 1. Access interChange.

STEP 2. Select Reference from the main menu.



InterChange Home Page

STEP 3 Select Related Data from the Reference submenu by clicking on it one time.



The Related Data panel will open.

STEP 4 Select “Other” from the left side of the Related Data panel by clicking on it one time.

STEP 5 Select the “ASC Pricing” link from the Related Data panel by clicking on it one time.



Related Data Panel

The ASC Pricing panel will open.

STEP 6. Select the applicable ASC Payment Group by clicking on the row one time.

The information from the row will populate in the fields below.

ASC Payment Group	Rate Type	Effective Date	End Date	Amount
ASC Group 1	Default	08/01/1997	12/31/2299	\$307.38
ASC Group 2	Default	08/01/1997	12/31/2299	\$412.79
ASC Group 3	Default	08/01/1997	12/31/2299	\$471.90
ASC Group 4	Default	08/01/1997	12/31/2299	\$582.25
ASC Group 5	Default	08/01/1997	12/31/2299	\$664.02
ASC Group 6	Default	08/01/1997	12/31/2299	\$775.59
ASC Group 7	Default	08/01/1997	12/31/2299	\$921.15
ASC Group 8	Default	08/01/1997	12/31/2299	\$911.55

ASC Payment Group	ASC Group 1	Rate Type	DEF - Default
Effective Date*	08/01/1997	End Date*	12/31/2299
Amount*	\$307.38		

5.11.1 Reference/ASC Pricing Panel Field Descriptions

Field	Description
ASC Payment Group	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.
Effective Date	The date an ASC rate becomes effective for claims processing.
Amount	Rate to be paid for an Ambulatory Surgical Center procedure. The rate is based on the ASC pricing group.
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.
End Date	The date an ASC rate is no longer in effect for claims processing.

5.11.2 Reference/ASC Pricing Panel Button Descriptions

Button	Description
Add	Add an ASC pricing segment.
Delete	Delete an ASC pricing segment.

5.11.3 Viewing ASC Procedure Reimbursement Rates for Rate Type DEF

STEP 1. Follow the instructions for **Viewing an ASC Payment Group**.

STEP 2. Click on the row that displays rate type DEF.

The information from the row will populate in the fields of the panel.

STEP 3. Follow the instructions for **Viewing ASC Procedure Reimbursement Rates**.

STEP 4. Click on the row the displays rate type DEF and the applicable ASC Payment Group.

The information from the row will populate in the fields of the panel.

5.11.4 Viewing ASC Procedure Reimbursement Rates for Rate Type OPA

STEP 1. Follow the instructions for **Viewing an ASC Payment Group**.

STEP 2. Click on the row that displays rate type OPA.

The information from the row will populate in the fields of the panel.

STEP 3. Follow the instructions for **Viewing ASC Procedure Reimbursement Rates**.

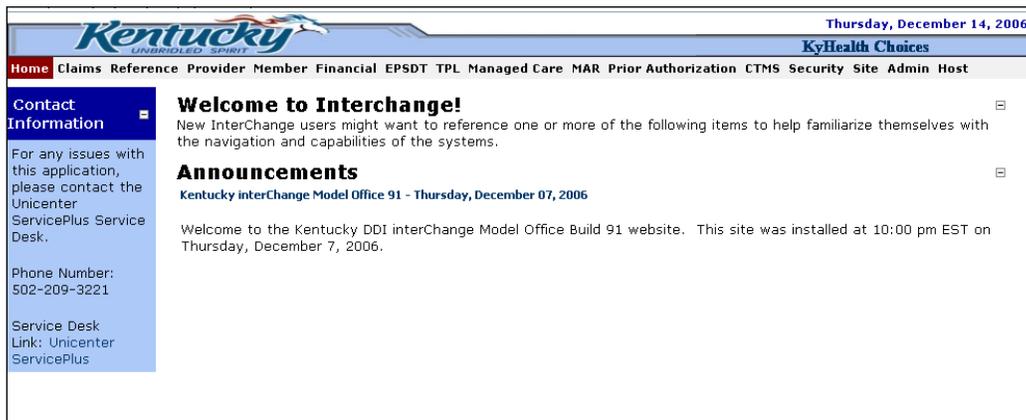
STEP 4. Click on the row the displays rate type OPA and the applicable ASC Payment Group.

The information from the row will populate in the fields of the panel.

5.12 Viewing a Revenue Code Flat Fee

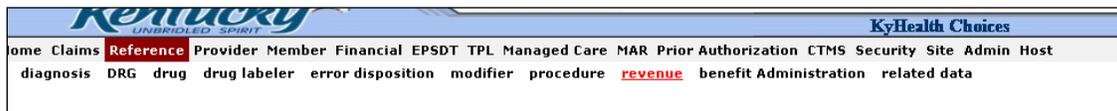
STEP 1. Access interChange.

STEP 2. Select Reference from the main menu.



InterChange Home Page

STEP 3. Select Revenue from the Reference menu.



This will open the Reference Revenue Search panel.



Reference / Revenue Search Panel

5.12.1 Revenue Search Panel Field Descriptions

Field	Description
Revenue	This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.
Description	This describes a specific accommodation or ancillary service.
Match criteria	Allows the user to specify criteria for matching based on “begins with” or “contains.”
Sounds-like	Allows the user to perform a phonetic search on description. If the box is checked, a phonetic search is performed using the input description. If the box is not checked a literal search is performed.
Records	Allows the user to specify the number of rows returned from the search.

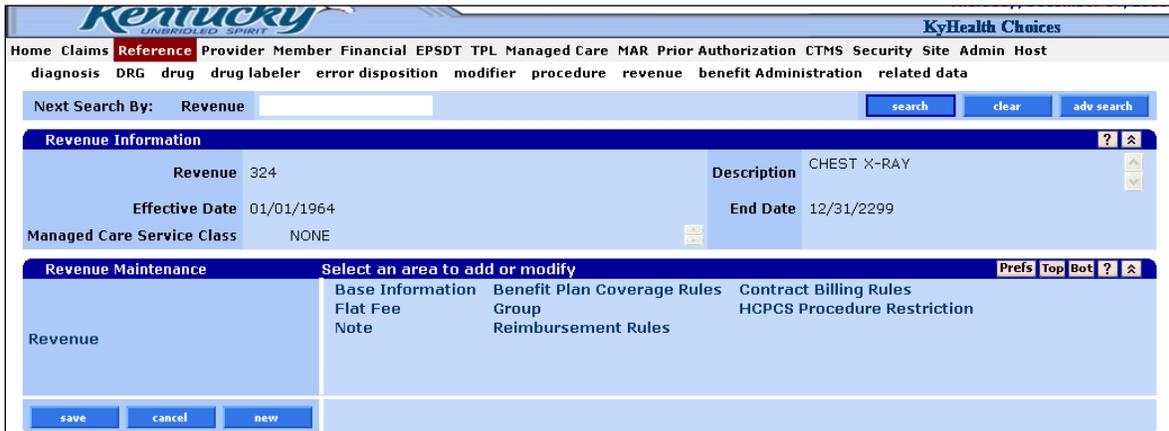
5.12.2 Revenue Search Panel Button Descriptions

Button	Description
Search	Initiates search on the database table for records matching the criteria entered.
Clear	Clears the criteria fields so user may enter new criteria.
Add	This button allows the user to create a new Revenue record.

STEP 4. Enter the revenue code in the Revenue field. Click on the “Search” button.



The following panels will open: Revenue Information panel and Maintenance panel.



Revenue Information and Maintenance Panels

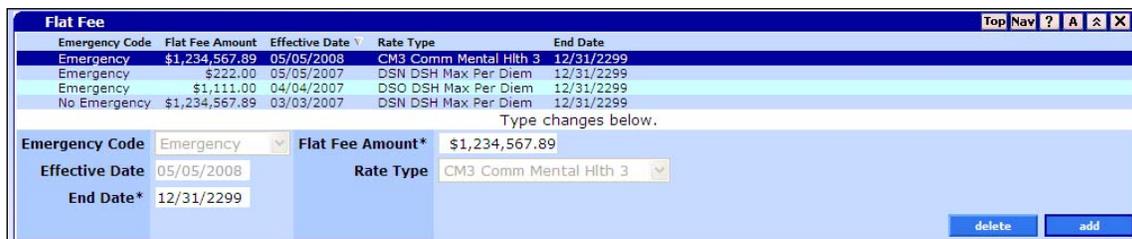
STEP 5. Select the “Flat Fee” link from the Revenue Maintenance panel by clicking on it one time.



Revenue Maintenance Panel

The Flat Fee panel will open.

STEP 6. Select a row by clicking on it one time. The information will populate into the fields of the panel.



Flat Fee Panel

5.12.3 Reference/Revenue/Flat Fee Panel Field Descriptions

Field	Description
-------	-------------

Emergency Code	A value that will denote if pricing should be computed at the emergency or non-emergency rate.
Effective Date	The date of service the emergency rate is effective for claims processing.
End Date	The date of service the emergency rate is no longer effective for claims processing.
Flat Fee Amount	The amount determined to be the flat fee. Format is 9999999.99.
Rate Type	The description of the rate type used in determining provider reimbursement.

5.12.4 Reference/Revenue/Flat Fee Panel Button Descriptions

Button	Description
Add	Allows user to add a new 'Flat Fee' for this revenue code.
Delete	Allows user to mark an existing flat fee structure to be removed from the revenue code.

5.12.5 Viewing the Revenue Flat Fee for Rate Type HO3

STEP 1. Follow the instructions for **Viewing a Revenue Code Flat Fee**

STEP 2. Select the row that displays rate type HO3.

The information from the row will populate in the fields of the panel.

5.12.6 Viewing the Revenue Flat Fee for Rate Type OP3

STEP 1. Follow the instructions for **Viewing a Revenue Code Flat Fee**

STEP 2. Select the row that displays rate type OP3.

The information from the row will populate in the fields of the panel.

5.12.7 Viewing the Revenue Flat Fee for Rate Type OP4

STEP 1. Follow the instructions for **Viewing a Revenue Code Flat Fee**

STEP 2. Select the row that displays rate type OP4.

The information from the row will populate in the fields of the panel.

5.12.8 Viewing the Revenue Flat Fee for Rate Type OP5

STEP 1. Follow the instructions for **Viewing a Revenue Code Flat Fee**

STEP 2. Select the row that displays rate type OP5.

The information from the row will populate in the fields of the panel.

5.12.9 Viewing the Revenue Flat Fee for Rate Type OP6

STEP 1. Follow the instructions for **Viewing a Revenue Code Flat Fee**

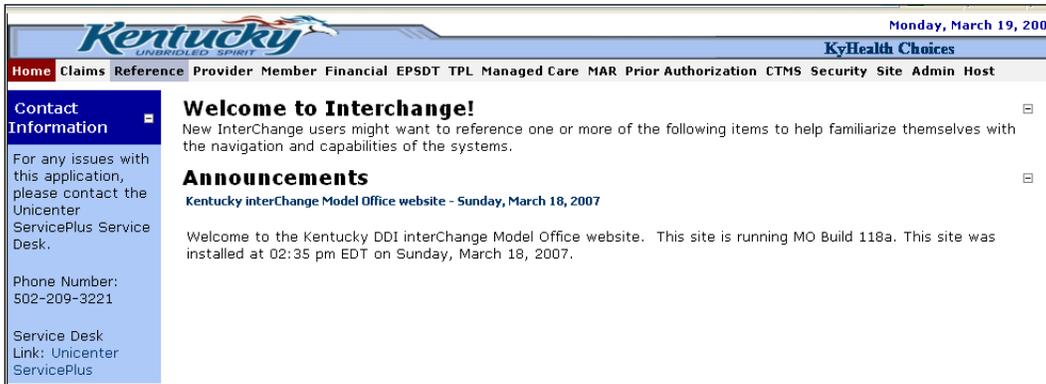
STEP 2. Select the row that displays rate type OP6.

The information from the row will populate in the fields of the panel.

5.13 Viewing the Benefit Adjustment Factor

STEP 1. Access interChange.

STEP 2. Select Reference from the main menu.



InterChange Home Page

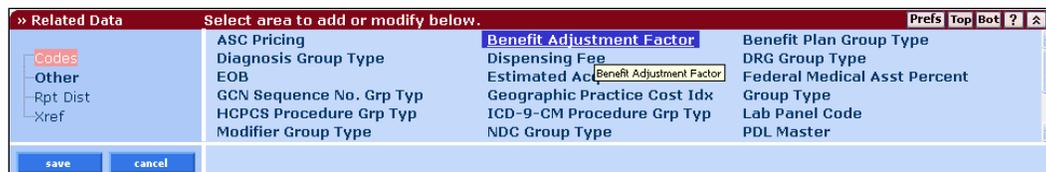
STEP 3 Select Related Data from the Reference submenu by clicking on it one time.



The Related Data panel will open.

STEP 4 Select “Other” from the left side of the Related Data panel by clicking on it one time.

STEP 5 Select the “Benefit Adjustment Factor” link from the Related Data panel by clicking on it one time.



Related Data Panel

The Benefit Adjustment Factor panel will open.

STEP 6. Select a row from the Benefit Adjustment Factor Type segment of the panel by clicking on it one time. The information will populate into the fields of the panel.

STEP 7. Select a row from the Benefit Adjustment Factor Rate segment of the panel by clicking on it one time. The information will populate into the fields of the panel.

The screenshot shows a software window titled "Benefit Adjustment Factor". It contains a list of BAF types and rates. The "Benefit Adjustment Factor Type" section shows a selected row with BAF* 40% and Description* Benefit Adjustment Factor rates are associated to a type via the Benefit Adjustment Factor Rate. The "Benefit Adjustment Factor Rate" section shows a table with columns Rate, Percent, Calculate Code, Effective Date, End Date, and Inactive Date. The selected row has Rate \$40.00, Percent 0.0%, Effective Date 03/20/2007, End Date 12/31/2299, and Inactive Date 12/31/2299. Below the table are input fields for Rate*, Percent*, Calculate Code*, Effective Date*, End Date*, and Inactive Date* with a dropdown menu for Calculate Code* showing options A - After and B - Before.

Benefit Adjustment Factor Panel

5.13.1 Reference/Related Data/Other/Benefit Adjustment Factor Panel Field Descriptions

Field	Description
BAF	Code to describe the benefit adjustment factor.
Description	Text description of the benefit adjustment factor.
Rate	Code to describe the rate.
Percent	Code to describe the percent.
Calculate Code	Option to select the calculate code.
Effective Date	Effective date of the BAF rate.
End Date	End date of the BAF rate.
Inactive Date	The date the BAF is inactive.

5.13.2 Reference/Related Data/Other/Benefit Adjustment Factor Panel Button Descriptions

Button	Description
-Benefit Adjustment Factor Type-	
Add	Add a benefit adjustment factor type.
Delete	Delete a benefit adjustment factor type.
-Benefit Adjustment Factor Rate-	
Add	Add a benefit adjustment factor rate.
Delete	Delete a benefit adjustment factor rate.

5.13.3 Viewing a Benefit Adjustment Factor of 60%

STEP 1. Follow the instructions for **Viewing the Benefit Adjustment Factor**.

STEP 2. Select the row that displays a BAF of 60%.

The information from the row will populate in the fields of the panel.

5.13.4 Viewing a Benefit Adjustment Factor of 65%

STEP 1. Follow the instructions for **Viewing the Benefit Adjustment Factor**.

STEP 2. Select the row that displays a BAF of 65%.

The information from the row will populate in the fields of the panel.

5.13.5 Viewing a Benefit Adjustment Factor of 75%

STEP 1. Follow the instructions for **Viewing the Benefit Adjustment Factor**.

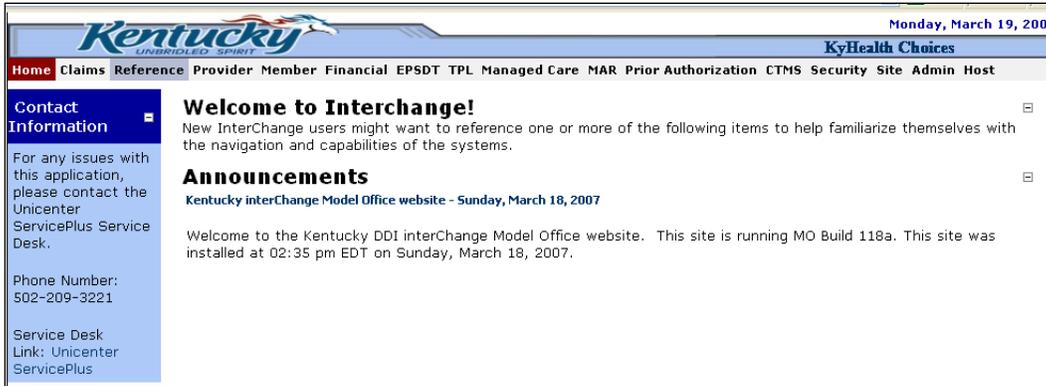
STEP 2. Select the row that displays a BAF of 75%.

The information from the row will populate in the fields of the panel.

5.14 Viewing a HCPCS Procedure Group Type

STEP 1. Access interChange.

STEP 2. Select Reference from the main menu.



InterChange Home Page

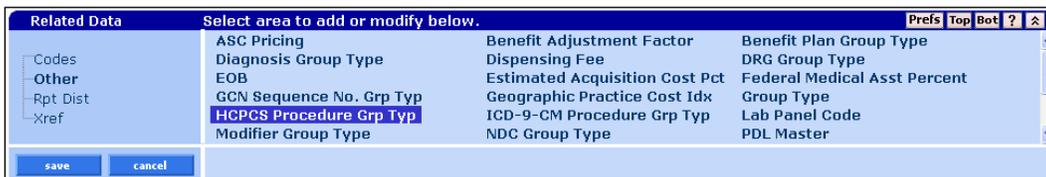
STEP 3 Select Related Data from the Reference submenu by clicking on it one time.



The Related Data panel will open.

STEP 4 Select “Other” from the left side of the Related Data panel by clicking on it one time.

STEP 5 Select the “HCPCS Procedure Group Type” link from the Related Data panel by clicking on it one time.



Related Data Panel

The HCPCS Procedure Group Type panel will open.

STEP 6. Select a row by clicking on it. Information will populate into fields on the panel.

HCPCS Procedure Group Type Panel

5.14.1 Reference/Related Data/Other/HCPCS Procedure Group Type Panel Field Descriptions

Field	Description
HCPCS Procedure Group Type	Unique system assigned key for the Procedure Group. Represents a collection of Procedures.
Description	Description of the HCPCS group type code.
Long Description	Group purpose. Definition of where and/or how this Procedure Group is used.
HCPCS Procedure Code Range From	A lower range of code which identifies a medical, dental, or DME procedure. If the range only covers 1 HCPC procedure code, the Start and End code will be the same.
HCPCS Procedure Code Range To	An upper range of code which identifies a medical, dental, or DME procedure. If the range only covers 1 HCPC procedure code, the Start and End code will be the same.
Effective Date	The date of service the procedure code becomes effective for the procedure type.

End Date	The date of service the procedure code is no longer effective for the procedure type.
----------	---

5.14.2 Reference/Related Data/Other/HCPSC Procedure Group Type Panel Button Descriptions

Button	Description
-HCPSC Procedure Group Type-	
Add	Add a HCPSC procedure group type.
Delete	Delete a HCPSC procedure group type.
-HCPSC Procedure Group-	
Add	Add a HCPSC procedure group.
Delete	Delete a HCPSC procedure group.

5.14.3 Viewing the HCPSC Procedure Group Type of 3013

STEP 1. Follow the instructions for **Viewing a HCPSC Procedure Group Type**.

STEP 2. Select the HCPSC Procedure Group Type 3013.

The information will populate in the fields of the panel.

STEP 3. Select the applicable procedure code range.

5.14.4 Viewing the HCPSC Procedure Group Type of 3014

STEP 1. Follow the instructions for **Viewing a HCPSC Procedure Group Type**.

STEP 2. Select the HCPSC Procedure Group Type 3014.

The information will populate in the fields of the panel.

STEP 3. Select the applicable procedure code range.

5.14.5 Viewing the HCPSC Procedure Group Type of 3072

STEP 1. Follow the instructions for **Viewing a HCPSC Procedure Group Type**.

STEP 2. Select the HCPSC Procedure Group Type 3072.

The information will populate in the fields of the panel.

STEP 3. Select the applicable procedure code range.

5.14.6 Viewing the HCPSC Procedure Group Type of 3073

STEP 1. Follow the instructions for **Viewing a HCPSC Procedure Group Type**.

STEP 2. Select the HCPSC Procedure Group Type 3073.

The information will populate in the fields of the panel.

STEP 3. Select the applicable procedure code range.

5.14.7 Viewing the HCPCS Procedure Group Type of 3074

STEP 1. Follow the instructions for **Viewing a HCPCS Procedure Group Type**.

STEP 2. Select the HCPCS Procedure Group Type 3074.

The information will populate in the fields of the panel.

STEP 3. Select the applicable procedure code range.

5.14.8 Viewing the HCPCS Procedure Group Type of 3075

STEP 1. Follow the instructions for **Viewing a HCPCS Procedure Group Type**.

STEP 2. Select the HCPCS Procedure Group Type 3075.

The information will populate in the fields of the panel.

STEP 3. Select the applicable procedure code range.

5.14.9 Viewing the HCPCS Procedure Group Type of 3097

STEP 1. Follow the instructions for **Viewing a HCPCS Procedure Group Type**.

STEP 2. Select the HCPCS Procedure Group Type 3097.

The information will populate in the fields of the panel.

STEP 3. Select the applicable procedure code range.

5.15 Viewing a Member's County Rate

STEP 1. Access interChange.



InterChange Home page

STEP 2. Select Reference from the main menu.



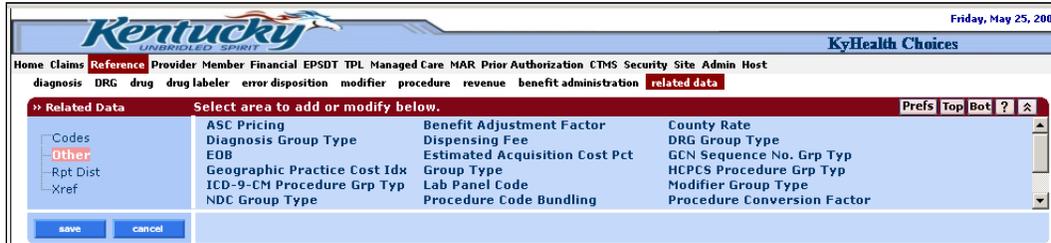
STEP 3. Select Related Data from the submenu.



The Related Data Panel will open.

STEP 4. Select “Other” from the left side of the Related Data Panel by clicking on it one time.

STEP 5. Select the “County Rate” link by clicking on it one time.



Reference Related Data Panel

The County Rate panel will open.



County Rate Panel

5.15.1 Reference County Rate Panel Field Descriptions

Field	Description
County	County code
Revenue Code	Revenue code
Rate Type	Rate type
Amount	Amount
Effective Date	Date when the county rate becomes effective.
Active Date	Date when the county rate becomes active.
End Date	Date when the county rate stops being valid.
Inactive Date	Date when the county rate becomes inactive.

5.15.2 Reference County Rate Panel Button Descriptions

Button	Description
Delete	Delete a county rate
Add	Add a new county rate

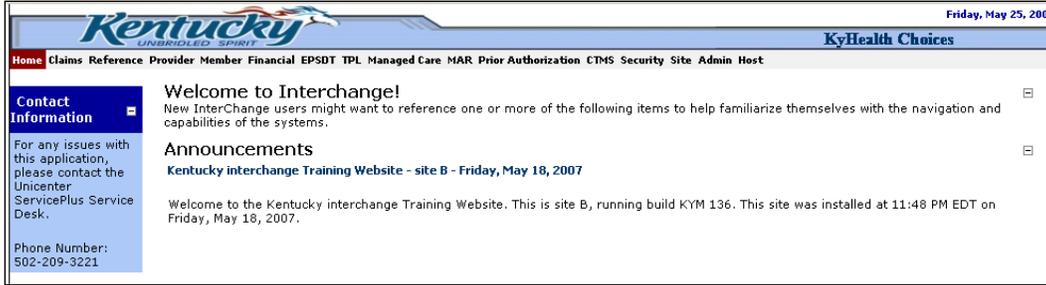
5.15.3 Viewing a Member’s County Rate for Rate Type HO1

- STEP 1. Follow the instructions for **Viewing a Member’s County Rate**.
- STEP 2. Select the row that displays rate type HO1.

The information from the row will populate in the fields of the panel.

5.16 Viewing a Fund Code Rate

- STEP 1. Access interChange.



interChange Home Page

STEP 2. Select Financial from the main menu.



STEP 3. Select Related Data from the submenu.



The Related Data panel will open.

STEP 4. Select “Other” from the left side of the Related Data panel by clicking on it one time.

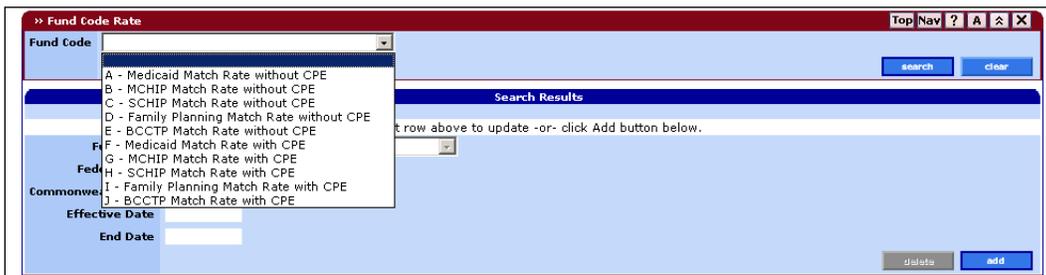


Financial Related Data Panel

STEP 5. Select the “Fund Code Rate” link by clicking on it one time.

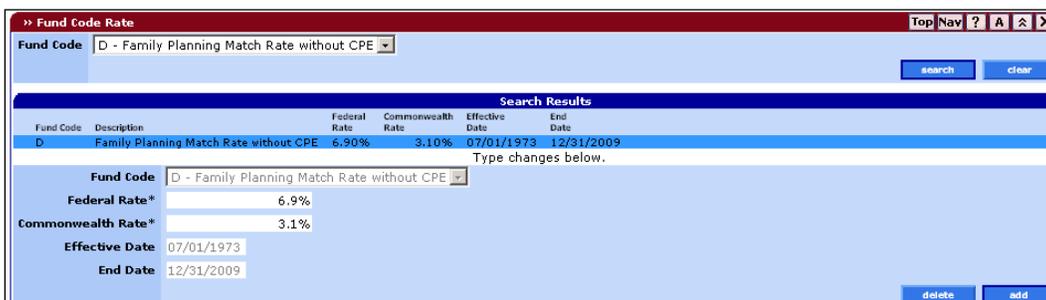
The Fund Code Rate Panel will open.

STEP 6. Select a fund code from the drop down field and click Search.



Fund Code Rate Panel

The Search Results will appear in the panel.



5.16.1 Financial Fund Code Rate Panel Field Descriptions

Field	Description
Fund Code	Fund code
Federal Rate	Federal rate
Commonwealth Rate	Commonwealth rate
Effective Date	Date when fund code becomes effective
End Date	Date when fund code becomes inactive

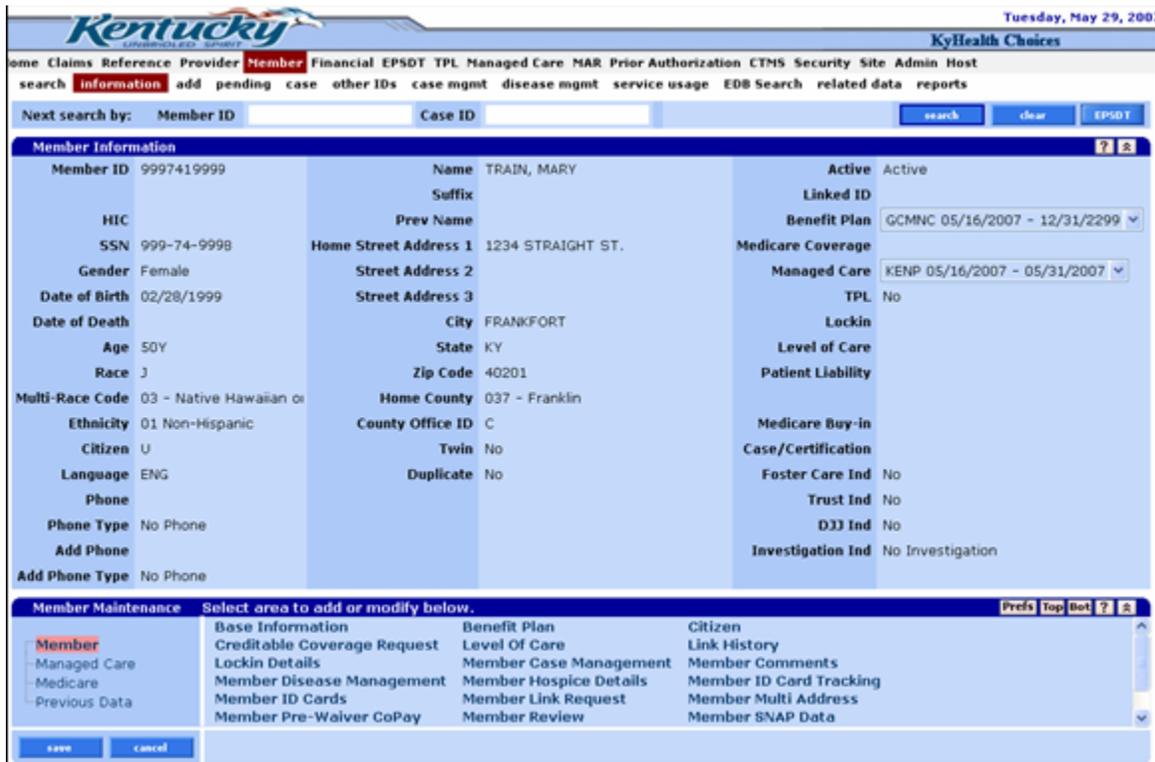
5.16.2 Financial Fund Code Rate Panel Button Descriptions

Button	Description
Delete	Delete a fund code rate
Add	Add a fund code rate

5.17 Viewing a Member's High Intensity Indicator (SNAP Data)

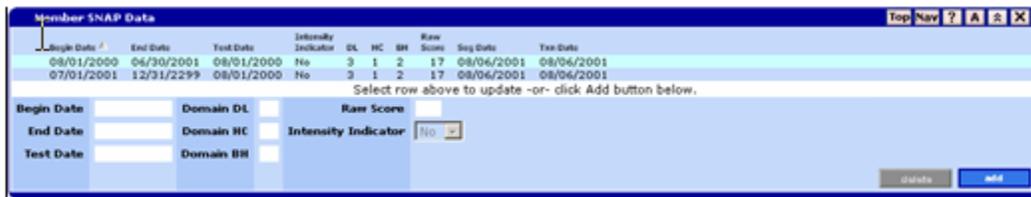
STEP 1. Access a Member file.

STEP 2. Select the “SNAP Data” link from the Member Maintenance panel by clicking on it one time.



Member Information and Maintenance Panels

The Member SNAP Data panel will open.



Member SNAP Data Panel

5.17.1 Member SNAP Data Panel Field Descriptions

Field	Description
Begin Date	The begin date of the member's SNAP segment.
Domain DL	This daily living domain score.
Raw Score	The Member's raw SNAP score.
End Date	The end date of the member's SNAP segment.

Domain HC	The health care domain score.
Intensity Indicator	The Hi Intensity Indicator. Y = Member Considered Hi Intensity and N = Member Not Considered Hi Intensity
Test Date	The date the SNAP test was administered.
Domain BH	The behavioral health domain score.

5.17.2 Member SNAP Data Panel Button Descriptions

Button	Description
Delete	Delete SNAP Data file
Add	Add SNAP Data file

5.17.3 Viewing a Member's High Intensity Indicator of Y

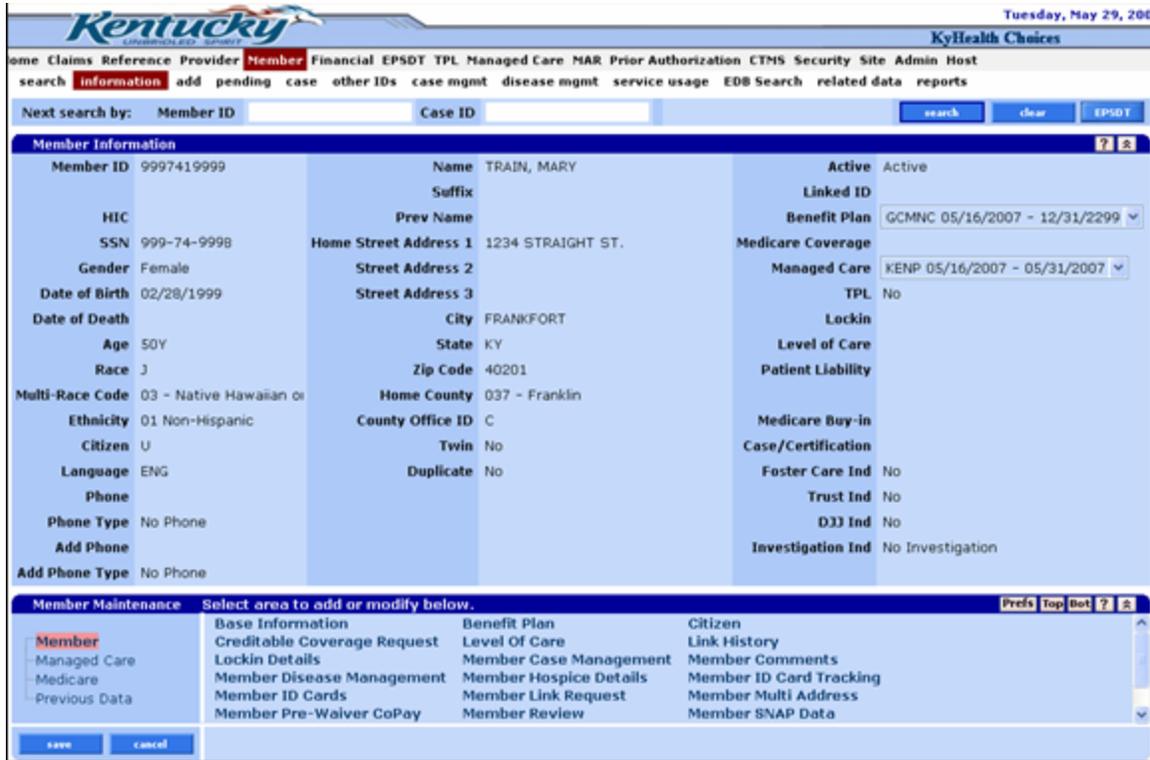
STEP 1. Follow the instructions for **Viewing a Member's High Intensity Indicator (SNAP Data)**.

STEP 2. Select a row that displays the Intensity Indicator of Yes.

The information from the row will populate in the fields of the panel.

5.18 Viewing a Member's Patient Liability

STEP 1. Access a Member file.



Member Information and Maintenance Panels

STEP 2. Click on the “Patient Liability” link located in the Member Maintenance panel. The Patient Liability panel will open.



5.18.1 Member Patient Liability Panel Field Descriptions

Field	Description
Monthly Amount	Patient's financial liability amount that must be paid by the member before the State will make payment on the claim
Type	Indicates which program to apply patient obligation.
Effective Date	Date that the patient's financial liability amount becomes effective.
End Date	Date that the patient's financial liability amount is no longer effective in a long term facility.

ICN	Internal Control Number which uniquely identifies a claim the patient liability was applied to.
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5.18.2 Member Patient Liability Panel Button Descriptions

Button	Description
Delete	Delete a Patient Liability record.
Add	Add a Patient Liability record.

5.19 Viewing a Member’s Case Spenddown

STEP 1. Access interChange.

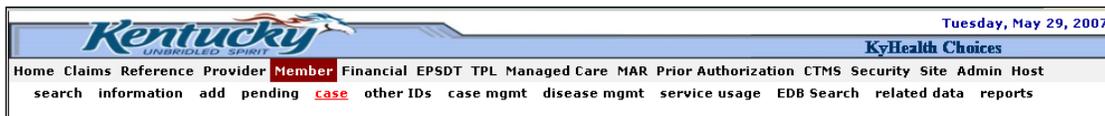


InterChange Home page

STEP 2. Select Member from the main menu.



STEP 3. Select Case from the submenu.



The Case Search panel will open.

STEP 4. Enter the search criteria and click the “Search” button.

Member Search			
Member ID	Last Name	Sounds-like <input type="checkbox"/>	
HIC	First Name		
Case Number	MI		
SSN	Gender	▼	
County	Date of Birth		
		Records	20 ▼
			search
			clear

The Case Information and Maintenance panels will open.



STEP 5. Click on the “Case Spenddown” link in the Case Maintenance panel.

The Case Spenddown panel will open.

STEP 6. Select a row by clicking on it one time.

The information from the row will populate in the fields of the panel.



5.19.1 Member/Case/Case Spenddown Panel Field Descriptions

Field	Description
Monthly Amount	The total amount of spenddown the case is responsible for during the specified time period.
Time Period Indicator	Indicates if the spenddown time period is monthly or a date span. The valid values are monthly and spanned.
Financial Payer	Contains financial payer types.
Provider Number	The identification number assigned to a group or individual that provides medical services to members.
Effective Date	The date the case starts being liable for spenddown amount.
End Date	The last date the case is responsible for spenddown payments.

5.19.2 Member/Case/Case Spenddown Panel Button Descriptions

Button	Description
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Delete	Delete a spenddown record.
Add	Add a spenddown record.