



Medicaid Information Technology System

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

Global Restrictions Participant Guide

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Course Overview

Overview

The goal of this course is to provide you with the information required to perform tasks associated with global restrictions.

Objectives

After completing this course you should be able to:

- Describe the purpose of global restrictions
- Identify how global restrictions impact Ohio Health Plans (OHP) policy
- Navigate in the global restrictions panels
- Add, modify, and delete global restrictions

Agenda

Topic	Time
Welcome and Introductions	10 minutes
Introduction to Rules	30 minutes
Introduction to Global Restrictions	30 minutes
Break	15 minutes
Maintaining Global Restrictions	90 minutes

Introduction to Rules

Overview

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

Rules as Policy

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

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

- Include parameters
- Exclude parameters
- Bypass parameters

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

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

Rules enable the State to:

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

Rule Directives

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

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

Types of Rules

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

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

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

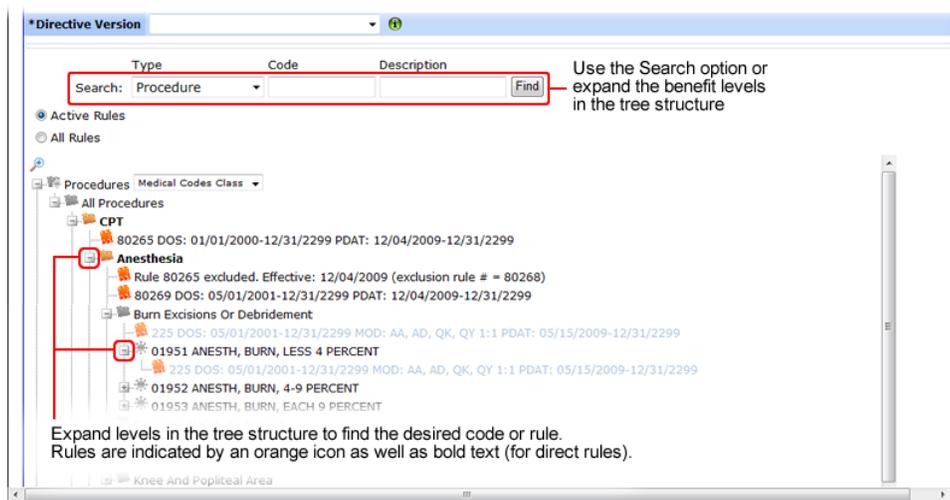
Another rule you might consider is for Other Insurance (OI), also referred to as Third Party Liability. The OI plan includes a list of services covered by the other carriers. OI plans might also cover services that the State Healthcare program covers. During the adjudication process, MITS compares service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

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

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

Tree Structure

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



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

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

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

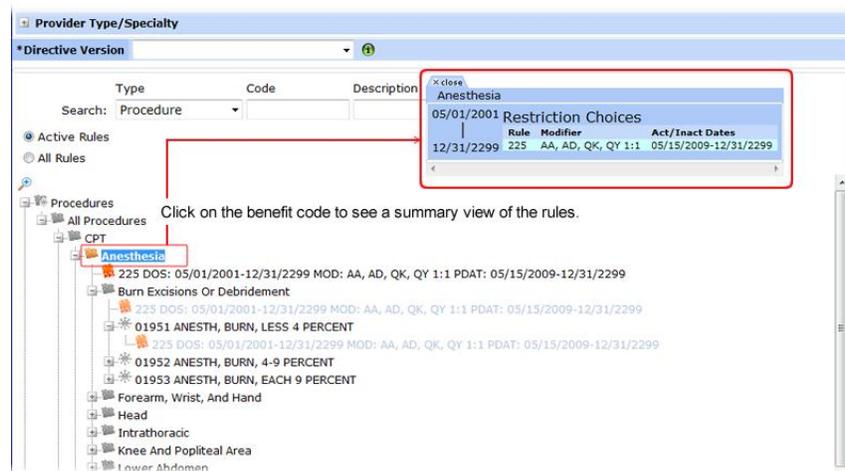
Review the table for more information on the benefit types, codes, and sources of information:

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

Rule Summary

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

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



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

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

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

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

Rule Categories

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

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

The screenshot shows the 'Provider Type/Specialty' interface with the 'Directive Version' set to 'CNV2009 v1 Release SYSTEM IMP'. The search criteria are 'Type: Procedure'. The left sidebar shows a tree view of 'Medical Codes Class' with 'CPT' expanded to 'Anesthesia'. A red box highlights the rule '225 DOS: 05/01/2001-12/31/2299 MOD: AA, AD, QK, QY 1:1 PDAT: 05/15/2009-12/31/2299' under the 'Anesthesia' group, with a callout: 'Direct rule – The benefit level is bold; and the rule displays normally.' Another red box highlights the procedure-level rules '01951 ANESTH, BURN, LESS 4 PERCENT', '01952 ANESTH, BURN, 4-9 PERCENT', and '01953 ANESTH, BURN, EACH 9 PERCENT', with a callout: 'Inherited (cascaded rule) – Rule was inherited by all the procedure codes below. Both the icon and the rule detail line are "grayed out" to indicate it is inherited, not direct.'

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

Check Your Understanding

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

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

- A. True
- B. False

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

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

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

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

Rules are put in place to deny claims.

- A. True
- B. False

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

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

Summary

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

Rule Options

Overview

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

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

Field options include edits for the following:

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

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

Yes/No Editing

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

The screenshot displays the 'Provider Type/Specialty' configuration page for a procedure. The left sidebar shows a tree view of procedure categories, with 'Anesthesia' selected. The main area shows a list of editing options, each with a dropdown menu. The 'Modifier Editing' option is highlighted with a red box and set to 'Yes'. A red circle highlights the 'Simplify' button next to the 'Yes' dropdown. A text box explains that when 'Yes' is selected, the 'Options' field and other options become available for editing.

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

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

Include/Exclude/No Editing

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



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

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

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

Assigned list	Add One (>) to move the selected items to the available list.
Remove all items from the Assigned field at one time:	Click Remove All (>>) . This moves all items back to the available list.

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

Include/Exclude/No with Multiple Selection Fields Editing

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

The table describes fields that use this option:

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

Example Logic:

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

Simplify

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

The screenshot shows a software interface for configuring diagnosis requirements. At the top, under the heading "Diagnosis", there are four dropdown menus: "Primary Diagnosis Header Editing" (No), "Diagnosis Header Secondary Editing" (No), "Admitting Diagnosis Editing" (No), and "Emergency Diagnosis Editing" (No). Below these is another dropdown menu "Diagnosis Detail Any Editing" (Yes), with a "Simplify" button highlighted in a red box to its right. The interface is divided into two main sections: "Options" on the left and "Diagnoses Assigned" / "Available Diagnoses" on the right. The "Options" section includes an "Add Option" button, a "Test Claim Value" field with four input boxes and a "Matches?" label, a "Maximum" field with the value "8", a "Minimum" field with the value "0", and a "Delete Requirement" button. The "Diagnoses Assigned" section contains an empty rectangular box and two arrow buttons (> and >>). The "Available Diagnoses" section shows a range from "0010" to "V8909" with left and right arrow buttons.

Add Requirement

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

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

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

The screenshot displays the 'Diagnosis Detail Any Editing' window. At the top, there is a dropdown menu set to 'Yes' and a 'Simplify' button. Below this is the 'Options' section, which contains a text input field with '[502-700]4' and a red-bordered 'Add Requirement' button. A red-bordered 'Add Option' button is also present. Underneath, there are 'Test Claim Value' and 'Matches?' fields. The 'Diagnoses Assigned' section shows a text box with '502 - 700' and navigation arrows '>' and '>>'. The 'Available Diagnoses' section lists three ranges: '< 0010 to 500', '< 501 to 501', and '< 7010 to V8909'. At the bottom left, there are 'Maximum 4' and 'Minimum 0' fields, with a 'Delete Requirement' button below them.

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

Check Your Understanding

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

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

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

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

- A. True
- B. False

Click this button to simplify the requirements.

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

Summary

In this topic, you learned about the rule options.

Save Process

Overview

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

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

System checks

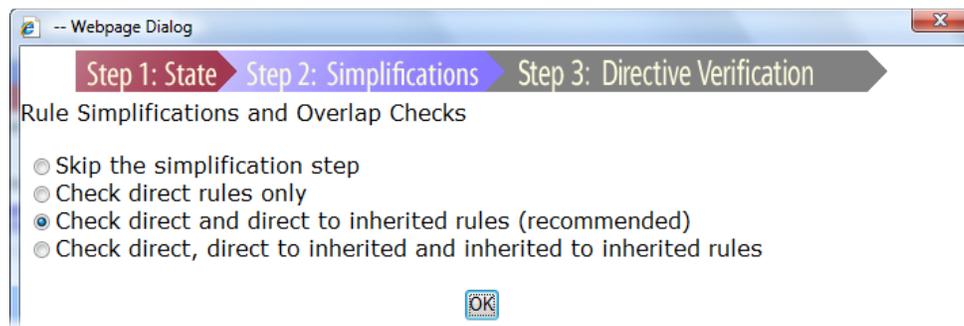
When you create a rule and attempt to save your changes, MITS launches a three-step save process to look for rule conflicts or errors. The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen directive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

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

Three Steps

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

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





Conflicts

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

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

Rule Simplifications and Overlap Checks

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

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

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

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

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

OK **Cancel Save**

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

Directive Version CNV2009 v1 Release SYSTEM IMP

Type	Code	Description
Search: Procedure		Find

Active Rules

All Rules

Procedures

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

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

Check Your Understanding

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

Which of the 3 steps identifies conflicting rules?

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

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

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

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

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

Summary

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

Introduction to Rule Modifier Editing

Overview

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

Modifier Editing Panel

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

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

Review the descriptions of the panel features.

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

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

Options: [QX, QZ]

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

Available Modifiers: 20 - MICROSURGERY, 21 - PROLONGED E&M SERVICE, 22 - UNUSUAL PROCEDURAL SE, 23 - UNUSUAL ANESTHESIA, 24 - UNRELATED E&M SAME MC

Test Claim Value: Maximum 1, Minimum 1

Matches? Matches?

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

Examples

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

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

For a procedure code to be adjudicated:

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

Screen shot - Rules modifier editing

Example 1: Current option modifier with additional options

Diagnosis Header Other Editing No

Provider Type/Specialty

Modifier Editing Yes Simplify

Options

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

Add Option

Test Claim Value Matches?

Inclusive

Maximum 1

Minimum 1

Delete Requirement

Modifiers Assigned

TH - OB TX/SRVCS PRENATL/POS

Available Modifiers

*** - AUDIT DEFAULT MODIFIER

20 - MICROSURGERY

21 - PROLONGED E&M SERVICE

22 - UNUSUAL PROCEDURAL SE

23 - UNUSUAL ANESTHESIA

24 - UNRELATED E&M SAME MC

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

Occurrence Editing No

Condition Editing No

Example 2: No modifiers allowed

Provider Type/Specialty

Modifier Editing Yes Simplify

Options

[**]0 Add Requirement

Add Option

Test Claim Value: Matches?

Modifiers Assigned

Inclusive

Maximum 0

Minimum 0

Delete Requirement

Available Modifiers

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

Occurrence Editing No

Note the following in this example:

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

Reimbursement Modifier Types

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

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

Check Your Understanding

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

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

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

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

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

Summary

In this topic you learned about Modifier editing options.

Introduction to Removing a Rule

Overview

There are three different ways to remove existing rules:

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

Three ways

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

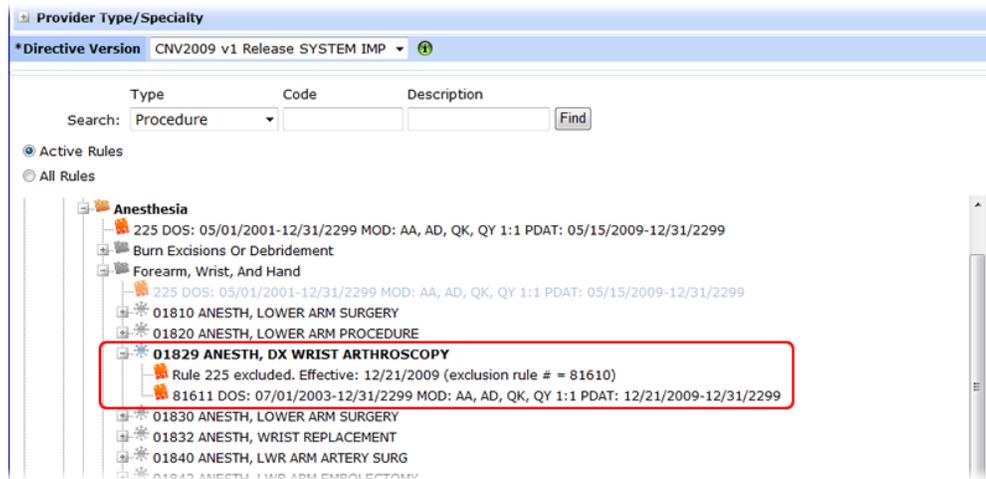
- The rule is a **direct** rule at the highest level that it applies.
- The rule is an **inherited** rule on codes that fall beneath the top level.

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

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

Example

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



Check Your Understanding

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

The Modify (Exclude/New) option:

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

Summary

In this topic you learned about removing rules.

Searching for Rules

Overview

What

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

Who

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

When

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

Relevance

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

Requirements

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

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

Guidelines

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

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

How To

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

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Provider Contract .						
4	Click the Provider Contract submenu group.						
5	Select the provider contract with these instructions: <table border="1" data-bbox="371 783 1373 1167"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the provider contract in the search field. b. Click search. Note: The matching provider contract will display (or a list if you only typed the first letter). </td> </tr> <tr> <td>Navigate the search results list</td> <td> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).	Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.
TO:	THEN:						
Search	a. Type the provider contract in the search field. b. Click search . Note: The matching provider contract will display (or a list if you only typed the first letter).						
Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the provider contract row from the Search Results list.						
6	Find the benefit code in the medical classification with these instructions: <table border="1" data-bbox="371 1272 1373 1707"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search the medical classification</td> <td> a. Select the desired type from the Type (i.e., Procedures, HCPCS, etc.) drop-down list. b. Enter the appropriate code in the Code field. c. You can search with the Description field, as well (if this would be effective). d. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service. </td> </tr> </tbody> </table>	TO:	THEN:	Search the medical classification	a. Select the desired type from the Type (i.e., Procedures, HCPCS, etc.) drop-down list. b. Enter the appropriate code in the Code field. c. You can search with the Description field, as well (if this would be effective). d. Click Find .	Navigate the tree	a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service.
TO:	THEN:						
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Navigate the tree	a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service.						
6	Click the benefit/service code level to view the rule summary.						

7	Click the rule to view the rule edit panel.
---	---

Success

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

Practice

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

Practice 1:

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

Record the rule number _____.

Be prepared to discuss the parameters for this rule.

Practice 2:

Practice searching for a rule using the following information:

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

Record the rule number(s) _____.

Be prepared to discuss the parameters for this rule.

Optional practices:

Practice viewing rules and the tree structure using this information:

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

Answer some questions about the rules you have just seen:

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

Learning points:

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

Summary

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

Q&A

Introduction to Global Restrictions

Overview

Global restrictions specify rules that apply across all contracts that are processed in the Ohio MITS system. There must be a global restriction associated with a benefit in order to process a claim with that benefit. In this topic you will learn what global restrictions are, why global restrictions are important, and how global restrictions impact and affect Ohio Medicaid policy.



A claim will not be paid if the claim includes a procedure for which there is no coverage in the global restriction rules.

Global Restrictions and MITS

When claims are processed, MITS first evaluates the global restrictions, which take precedence over other rules. After a claim processes global restrictions, it processes the other Benefit Plan Administration (BPA) rules such as the provider contract and reimbursement rules.

Global Restrictions and OHP Policy

Global restriction rules enforce global BPA rules for **all** providers, unless otherwise noted. In order to determine whether to reimburse a provider for a service, MITS **first** determines the global restrictions before evaluating the provider contract.

To learn more about how global restrictions enforce Ohio Health Plans (OHP) policy, review the following scenarios:



Scenario 1: Procedure code 99213 is submitted on a claim for for a recipient that is 18 years old and the claim is denied.

- The mental health provider contract covers this procedure.
- Global restrictions do not cover this procedure.

Outcome: The claim is denied. There is **no** global restriction rule that provides coverage for procedure code 99213.



Scenario 2: Procedure code 99213 is submitted on a claim for a recipient who is 18 years old and claim is denied.

- Global restrictions have open coverage with no restrictions for procedure code 99213.
- The provider contract restricts coverage for procedure code 99213 to recipients above the age of 21.

Outcome: The claim is denied. After processing through global restrictions, the claim is denied under the age restriction rule in the provider contract.



Scenario 3: Procedure code 99213 is submitted on a claim for a recipient who is 18 years old and there is a conflicting rule between global restrictions and the provider contract.

- The provider contract covers recipients age 18 years and older.
- The global restriction covers only recipients age 21 years and older.

Outcome: The claim is denied. The global restriction rule overrides the provider contract rule.



Scenario 4: Procedure code 99213 is submitted on a claim for a recipient who is 18 years old and the claim is paid.

- A global restriction rule covers procedure code 99213 for ages 18 and older for all mental health providers.
- The provider contract rule has no coverage restrictions.

Outcome: The claim is paid. The global restriction and provider contract rules allow for the procedure to be covered.

Navigating in the Global Restrictions Panel

The Global Restrictions panel allows you to search on all benefit types (procedures, diagnosis, ICD-9 procedures, revenue codes, Diagnoses Related Groups (DRGs)) to access the associated rules and restrictions. Use the panels to add, modify, list, and inactivate existing rules. You can also exclude inherited rules as necessary.

Review the panel below to learn more.

Global Restrictions

Benefit Administration Select area to add or modify below. Prefs Top Bot ? ↕

- Benefit Classification
- Copay
- Financial Payer
- Form Edits
- Global Restrictions** — Set up global restrictions from the Benefit Administration panel.
- Recipient Plan
- Other Insurance
- Provider Contract
- Reimbursement Agreement
- Rule Catalog

save cancel

Global Restrictions Top Nav ? ↕ X

*Directive Version CNV2009 v1 Release SYSTEM IMP ⓘ

Type Code Description

Search: Procedure 75894

Active Rules
All Rules

Search by Code or by Type, for example, Procedure or Diagnosis.

Procedures

- All Procedures
- Category II
- Category III
- CPT**

75893 DOS: 01/01/2000-12/31/2299 PDAT: 10/29/2009-12/31/2299 POS: (09)

Rules display below the category in bold.

75894 X-RAYS, TRANSCATH THERAPY

01/01/2000 Restriction Choices

Rule	Act/Inact Dates	Place of Service
12/31/2299 i75893	10/29/2009-12/31/2299	(09)

Global Restrictions

Global Restrictions *Directive Version: CNV2009 v1 Release SYSTEM IMP

Search: Procedure [] []

Active Rules (selected) / All Rules

Procedures

- All Procedures
- Category II
- Category III
- CPT
 - 75893 DOS: 01/01/2000-12/31/2299 PDAT: 10/29/2009-12/31/2299 POS: (09)
 - Anesthesia
 - 75893 DOS: 01/01/2000-12/31/2299 PDAT: 10/29/2009-12/31/2299 POS: (09)
 - Burn Excisions or Debridement
 - 75893 DOS: 01/01/2000-12/31/2299 PDAT: 10/29/2009-12/31/2299 POS: (09)
 - 01951 ANESTH, BURN, LESS 4 PERCENT** (highlighted with red box and "Add Rule" button)
 - 01952 ANESTH, BURN, 4-9 PERCENT
 - 01953 ANESTH, BURN, EACH 9 PERCENT
 - Forearm, Wrist, and Hand
 - Head
 - Intrathoracic

01951 ANESTH, BURN, LESS 4 PERCENT

01/01/2000 Restriction Choices

Rule	Place of Service	Act/Inact Dates
95676	09	08/18/2010-12/31/2299
175893	(09)	10/29/2009-12/31/2299

Right-click to add, modify or inactivate a rule.

Global Restrictions

Global Restrictions *Directive Version: CNV2009 v1 Release SYSTEM IMP

Search: Procedure [] []

Active Rules (selected) / All Rules

Procedures

- All Procedures
- Category II
- Category III
- CPT
 - 75893 for Procedures - All Procedures - CPT
 - Anesthesia
 - 75893 DOS: 01/01/2000-12/31/2299 PDAT: 10/29/2009-12/31/2299 POS: (09)
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 - 01953 ANESTH, BURN, EACH 9 PERCENT
 - Forearm, Wrist, and Hand
 - Head
 - Intrathoracic

75893 for Procedures - All Procedures - CPT

Created By: QZ9GMZ

View History

Created On: [] Last saved via: []

Eff/End Dates: 01/01/2000 12/31/2299

Age: 0 999999

Quantity: 0 999999

Medical Review: No

Referring Provider Indicator: Both

Place of Service Editing: Exclude

Places Of Service Assigned: 09 - Prison-Correctional Facility

Available Places Of Service:

- 01 - Pharmacy
- 02 - Unassigned
- 03 - School
- 04 - Homeless Shelter
- 05 - Indian Health Service - Fr
- 06 - Indian Health Service Prov

Level of Care Editing: No

Right-click on an existing rule to inactivate the rule.

Global Restrictions

Global Restrictions Top Nav ? A X

*Directive Version CNV2009 v1 Release SYSTEM IMP

Search: Type: Procedure Code: Description: 75893 for Procedures - All Procedures - CPT

Created By: QZ9GMZ Created On: Last saved via:

View History

Eff/End Dates: 01/01/2000 12/31/2299 Claims Submission:

Age: 0 999999 Act/Inc:

Quantity: 0 999999

Medical Review: No

Referring Provider Indicator: Both

Type of Bill Editing: No

Place of Service Editing: Exclude

Places Of Service Assigned: 09 - Prison-Correctional Facility

Available Places Of Service: 01 - Pharmacy, 02 - Unassigned, 03 - School, 04 - Homeless Shelter, 05 - Indian Health Service - Fr, 06 - Indian Health Service Prov

Level of Care Editing: No

Left-click on an existing rule to update the rule.

Check Your Understanding

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

Global restriction rules apply to all providers unless otherwise noted.

- A. True
- B. False

Complete the following statement:

In order to determine whether to reimburse a provider for a service,
_____.

- A. MITS evaluates the provider contract before evaluating global restrictions.
- B. MITS first evaluates the global restrictions before evaluating the provider contract.
- C. MITS only evaluates the global restrictions.
- D. MITS only evaluates the provider contract rules.

Summary

In this topic you learned what global restrictions are, why global restrictions are important, and how global restrictions impact and affect Ohio Medicaid policy.

Maintaining Global Restrictions

Overview

What

In this topic you learn how to add, modify, or delete global restrictions. Global restrictions are global rules that apply across all contracts. You can add, modify, or delete global restrictions for procedures, diagnoses, ICD-9 procedures, revenue codes, and Diagnosis Related Groups (DRGs).

Who

The Ohio Health Plans (OHP) Rules Analyst performs this task.

When

Maintain global restrictions when there are new policies associated with a directive.

Relevance

Maintaining global restrictions is important because it allows rules that pertain to all providers (unless otherwise noted) to be set once. This reduces the number of rules needed to enforce Benefit Plan Administration (BPA) policy.

Requirements

The following requirements apply to global restrictions:

- To add, modify, or inactivate/exclude a global restriction, select an approved directive.
- To pay a claim, make sure there is coverage in global restrictions. A claim fails if the claim includes a benefit for which there is no coverage in the global restrictions.
Note: If global restrictions conflict with a provider contract, the global restrictions take precedence.
- Do not apply global restrictions for drugs; MITS does not process pharmaceutical claims.

Guidelines

The following guidelines apply to global restrictions:

- Use global restrictions to implement global policies that apply to all providers (unless otherwise noted). For example, if procedure code 99213 has a coverage rule under a specific provider contract but has no global restriction coverage rules, the claim fails.
- Apply rules at the top level (folder/group) to apply to all items in the subgroups below.
- Select the **Include** or **Exclude** option for a rule to expand the panels below and assign the appropriate options.
- Select the **Yes** or **No** options for a rule to expand the panels to show additional options that you can apply.

Adding, Modifying, and Inactivating Global Restrictions

Follow these steps from the MITS home page to add global restrictions:

Step	Action												
1	Click Benefit Administration from the Reference subsystem.												
2	Click Global Restrictions .												
3	Select a directive from the Directive Version drop-down list.												
4	To locate the level where you want to find a rule, follow these steps: <table border="1" data-bbox="371 722 1375 1062"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
TO:	THEN:												
Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .												
Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.												
5	<p>Right-click on the benefit group or code and select Add Rule to add a global restriction as specified below.</p> <p>Note: Some options are available only when you click a specific type. For example, you can specify Level of Care exclusion or inclusion options for revenue codes.</p> <table border="1" data-bbox="371 1306 1375 1770"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Specify effective dates</td> <td>Type the start and end date of the global restriction in the Eff/End Dates fields.</td> </tr> <tr> <td>Specify age restrictions</td> <td>Type the age range in the corresponding Age fields.</td> </tr> <tr> <td>Specify a quantity</td> <td>Type a quantity in the Quantity field.</td> </tr> <tr> <td>Specify a medical review requirement</td> <td>Select Yes or No from the Medical Review drop-down list.</td> </tr> <tr> <td>Specify a referring provider</td> <td>Select Yes or No from the Referring Provider Indicator drop-down list.</td> </tr> </tbody> </table>	TO:	THEN:	Specify effective dates	Type the start and end date of the global restriction in the Eff/End Dates fields.	Specify age restrictions	Type the age range in the corresponding Age fields.	Specify a quantity	Type a quantity in the Quantity field.	Specify a medical review requirement	Select Yes or No from the Medical Review drop-down list.	Specify a referring provider	Select Yes or No from the Referring Provider Indicator drop-down list.
TO:	THEN:												
Specify effective dates	Type the start and end date of the global restriction in the Eff/End Dates fields.												
Specify age restrictions	Type the age range in the corresponding Age fields.												
Specify a quantity	Type a quantity in the Quantity field.												
Specify a medical review requirement	Select Yes or No from the Medical Review drop-down list.												
Specify a referring provider	Select Yes or No from the Referring Provider Indicator drop-down list.												

Specify claims submission dates	Type the start and end dates in the Claims Submission Dates fields.
Specify a gender	Select Male or Female from the Gender drop-down list.
Specify prior authorization options	Select the applicable option from the Prior Auth drop-down list.
Specify bill editing options	<ol style="list-style-type: none"> Select Include or Exclude from the Type of Bill Editing drop-down list. Select the option to include or exclude from the Available Type of Bill Codes by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the Type of Bill Codes Assigned list.
Specify place of service options	<ol style="list-style-type: none"> Select Include or Exclude from the Place of Service Editing drop-down list. Select the option to include or exclude from the Available Places of Service by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the Places of Service Assigned list.
Specify level of care editing	<ol style="list-style-type: none"> Select Include or Exclude from the Level of Care Editing drop-down list. Select the option to include or exclude from the Available Level of Care Codes by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the Level of Care Codes Assigned list.
Specify claim type editing	<ol style="list-style-type: none"> Select Include or Exclude from the Claim Type Editing drop-down list. Select the option to include or exclude from the Available Claim Types by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the Claim Types Assigned list.
Specify diagnosis	<ol style="list-style-type: none"> Click + alongside the Diagnosis title to expand the options. Select Include or Exclude from the applicable diagnosis editing drop-down list. Select the option to include or exclude from the Available Diagnosis list by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the Diagnosis Assigned list.
Specify a provider type specialty	<ol style="list-style-type: none"> Click + alongside the Provider Type/Specialty title to expand the options. Select Include or Exclude from the applicable

			<p>provider type specialty drop-down list.</p> <p>c. Select the option to include or exclude from the Available Type Specialties list by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the Type Specialties Assigned list.</p>
	Specify ICD-9 procedure editing		<p>a. Select Include or Exclude from the ICD-9 Procedure drop-down list.</p> <p>b. Select the option to include or exclude from the Available ICD-9 Procedures by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the ICD-9 Procedures Assigned list.</p>
	Specify procedure editing		<p>a. Select Include or Exclude from the Place of Service Editing drop-down list.</p> <p>b. Select the option to include or exclude from the Available Places of Service by clicking the option on the expanded menu and then clicking the left arrow (<) to add it to the Places of Services Assigned list.</p>
	Specify ICD-9 procedure, procedure, modifier, condition or occurrence editing		<p>a. Select yes from the associated drop-down list.</p> <p>b. Click to select the combination of modifier code(s) from the Available Modifiers list.</p> <p>c. Click the left arrow to (<) to move the selected modifiers to the Modifiers Assigned list.</p>
6	Configure ICD-9 procedure, procedure, modifier, condition or occurrence editing modifier options by following these steps:		
		TO:	THEN:
	Add assigned modifier codes		<p>a. Click to select the combination of Modifier code(s) from the Available Modifiers pick list.</p> <p>b. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box.</p>
	Modify the current option		<p>a. Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule.</p> <p>b. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field.</p> <p>c. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field.</p> <p>d. Click to select the combination of Modifier code(s) from the Available Modifiers pick list.</p> <p>e. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list.</p>

	<table border="1"> <tr> <td data-bbox="375 205 724 411">Disallow any modifier codes on claim</td> <td data-bbox="724 205 1377 411"> <ul style="list-style-type: none"> a. Ensure the Inclusive checkbox is checked. b. Select the first available modifier option ** - Audit Default Modifier. c. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0). </td> </tr> <tr> <td data-bbox="375 411 724 743">Add modifier requirements (AND condition)</td> <td data-bbox="724 411 1377 743"> <ul style="list-style-type: none"> a. Click Add Requirement. b. Click the area with the dotted line after and. c. Click the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned pick list. e. Click to select (or deselect) the Inclusive checkbox. f. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0). </td> </tr> <tr> <td data-bbox="375 743 724 1075">Add modifier option (OR condition)</td> <td data-bbox="724 743 1377 1075"> <ul style="list-style-type: none"> a. Click Add Option. b. Click the brackets inside the dotted line box. c. Click to select the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned list. e. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. f. Type the minimum number of Modifier codes allowed (1-4) in the Minimum field. </td> </tr> </table>	Disallow any modifier codes on claim	<ul style="list-style-type: none"> a. Ensure the Inclusive checkbox is checked. b. Select the first available modifier option ** - Audit Default Modifier. c. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0). 	Add modifier requirements (AND condition)	<ul style="list-style-type: none"> a. Click Add Requirement. b. Click the area with the dotted line after and. c. Click the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned pick list. e. Click to select (or deselect) the Inclusive checkbox. f. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0). 	Add modifier option (OR condition)	<ul style="list-style-type: none"> a. Click Add Option. b. Click the brackets inside the dotted line box. c. Click to select the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned list. e. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. f. Type the minimum number of Modifier codes allowed (1-4) in the Minimum field.
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7	<p>Add additional modifier options by following these steps:</p> <table border="1"> <thead> <tr> <th data-bbox="375 1180 724 1234">TO:</th> <th data-bbox="724 1180 1377 1234">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1234 724 1495">Simplify</td> <td data-bbox="724 1234 1377 1495"> <p>Click Simplify.</p> <p>Note: The Simplify button reviews the options and reduces or combines the entered Option settings in order to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered.</p> </td> </tr> <tr> <td data-bbox="375 1495 724 1808">Test Claim Matches</td> <td data-bbox="724 1495 1377 1808"> <ul style="list-style-type: none"> a. Type modifier value(s). b. Click Matches?. <p>Note: These fields test the system to confirm that the entered modifier rules and values are correct. Once all of the options have been completed, enter up to four values that will either cause a claim to match the selected modifiers, or enter values that will cause the test to return the "Does not match" message.</p> </td> </tr> </tbody> </table>	TO:	THEN:	Simplify	<p>Click Simplify.</p> <p>Note: The Simplify button reviews the options and reduces or combines the entered Option settings in order to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered.</p>	Test Claim Matches	<ul style="list-style-type: none"> a. Type modifier value(s). b. Click Matches?. <p>Note: These fields test the system to confirm that the entered modifier rules and values are correct. Once all of the options have been completed, enter up to four values that will either cause a claim to match the selected modifiers, or enter values that will cause the test to return the "Does not match" message.</p>
TO:	THEN:						
Simplify	<p>Click Simplify.</p> <p>Note: The Simplify button reviews the options and reduces or combines the entered Option settings in order to simplify the requirements. When the requirements are simplified, the combined results are logically equivalent to what was originally entered.</p>						
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8	Click Save to launch a three-step save process. Note: The first two steps interpret the rules and compare the new rule to existing rules, looking for overlaps and ambiguities. The third step validates the chosen directive and version.
9	<u>If the save is successful</u> , click OK to dismiss the confirmation window.
10	If the system finds a conflict: a. Click Cancel Save . b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again).

Follow these steps from the MITS home page to modify global restrictions:

Step	Action						
1	Click Benefit Administration from the Reference subsystem.						
2	Click Global Restrictions .						
3	Select a directive from the Directive Version drop-down list.						
4	To locate the level where you want to update a rule, follow these steps: <table border="1" data-bbox="371 1062 1373 1402"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td>a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find.</td> </tr> <tr> <td>Navigate the tree</td> <td>a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.</td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.
TO:	THEN:						
Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .						
Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
5	To modify a direct or inherited global rule: a. <u>IF you want to modify a direct global restriction rule</u> , click to expand the rule criteria. b. <u>IF you want to modify an inherited global restriction rule</u> , right click the rule and select Modify Rule (Excl/New) . c. Click the corresponding menu that displays and update the rule as appropriate.						
6	Click Save to launch a three-step save process. Note: The first two steps interpret the rules and compare the modified rule to existing rules, looking for overlaps and ambiguities. The third step validates the chosen directive and version.						

7	<u>If the save is successful</u> , click OK to dismiss the confirmation window.
8	If the system finds a conflict: <ol style="list-style-type: none"> Click Cancel Save. Make the appropriate changes to the rule to resolve the conflict. Click Save (again).

Follow these steps from the MITS home page to inactivate/exclude global restrictions:

Step	Action						
1	Click Benefit Administration from the Reference subsystem.						
2	Click Global Restrictions .						
3	Select a directive from the Directive Version drop-down list.						
4	To locate the level where you want to update a rule, follow these steps: <table border="1" data-bbox="371 890 1373 1234"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> <ol style="list-style-type: none"> Select the desired type from the Type drop-down list. Type the appropriate code in the Code field. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> <ol style="list-style-type: none"> Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	<ol style="list-style-type: none"> Select the desired type from the Type drop-down list. Type the appropriate code in the Code field. Click Find. 	Navigate the tree	<ol style="list-style-type: none"> Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. Continue to click the “+” symbol until you reach the desired level.
TO:	THEN:						
Search	<ol style="list-style-type: none"> Select the desired type from the Type drop-down list. Type the appropriate code in the Code field. Click Find. 						
Navigate the tree	<ol style="list-style-type: none"> Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. Continue to click the “+” symbol until you reach the desired level. 						
5	To inactivate a direct rule or exclude an inherited global restriction rule, follow these steps: <table border="1" data-bbox="371 1369 1373 1606"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Inactivate an inherited rule</td> <td>Right-click on the inherited rule in the tree structure and select Inactivate.</td> </tr> <tr> <td>Exclude a direct rule</td> <td>Right-click on the direct rule in the tree structure and select Exclude Rule.</td> </tr> </tbody> </table>	TO:	THEN:	Inactivate an inherited rule	Right-click on the inherited rule in the tree structure and select Inactivate .	Exclude a direct rule	Right-click on the direct rule in the tree structure and select Exclude Rule .
TO:	THEN:						
Inactivate an inherited rule	Right-click on the inherited rule in the tree structure and select Inactivate .						
Exclude a direct rule	Right-click on the direct rule in the tree structure and select Exclude Rule .						
6	Click Save to launch a three-step save process. Note: The first two steps interpret and compare rules, looking for overlaps and ambiguities. The third step validates the chosen directive and version.						
7	<u>If the save is successful</u> , click OK to dismiss the confirmation window.						

8	If the system finds a conflict: a. Click Cancel Save . b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again).
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Success

After a global rule or restriction is saved, MITS checks for conflicting rules and ambiguities and displays warnings if there are any conflicts or errors. Reconcile any conflicts or errors to successfully complete this task. A message confirms that the new rule, modified rule, or deletion has been saved.

After you add, modify, or delete a global restriction, claims can process through the global restrictions before processing through the provider contract to determine the final coverage and payment.

Practice - Adding Global Restrictions

Add a global restriction using this information:

- **Anesthesia Procedure Code:** Your choice, for example, 01951, 01952, and so on
- **Place of Service: Exclude** the Homeless Shelter
- **Effective end date:** Next business day

After you add a global restriction, describe the three-step save process for global restrictions.

Practice - Modifying Global Restrictions

Modify the global restriction rule for the anesthesia procedure code you created in the previous exercise to make the effective date one day later.

After you update the global restriction, describe the three-step save process for global restrictions.

Practice - Inactivating Global Restrictions

Inactivate a Global Restriction:

Inactivate the global restriction you created and modified in the two previous exercises.

After you inactivate the global restriction, describe how inactivating a global restriction is different from modifying a global restriction.

Review

Objectives

In this course you learned how to:

- Describe the purpose of global restrictions
- Identify how global restrictions impact OHP policy
- Navigate in the global restrictions panels
- Add, modify, and delete global restrictions